

**OREGON HEALTH PLAN  
MEDICAID DEMONSTRATION**

**Capitation Rate Development  
Federal Fiscal Year 2004**

**Submitted by:**

**PricewaterhouseCoopers LLP  
199 Fremont Street  
San Francisco, CA 94105**

**September 2003**

September 30, 2003

Ms. Maureen King  
OHP Actuarial Services Manager  
Office of Medical Assistance Programs  
500 Summer Street NE  
Salem, Oregon 97310-1014

Dear Maureen:

**Re: Capitation Rates for the Oregon Health Plan Medicaid  
Demonstration**

We have calculated the capitation rates to be paid to contracting physical health, mental health, dental, and chemical dependency plans under the Oregon Health Plan Medicaid Demonstration for October 1, 2003 through September 30, 2004. These capitation payments are based on our previous work described in detail in our report to you entitled Analysis of Federal Fiscal years 2004-2005 Average Costs and dated November 11, 2002 and reflect coverage of services through line 549 of the prioritized list.

The following report describes the methods used for calculating the capitation payments.

\* \* \*

Please call me if you have any questions regarding these capitation rates or the methods that were used in the calculation.

Very Truly Yours,

PricewaterhouseCoopers LLP

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By: Sandra S. Hunt, M.P.A.  
Principal

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Peter B. Davidson, A.S.A., M.A.A.A.  
Senior Consultant

**Actuarial Certification of  
Proposed Oregon Health Plan Capitation Rates  
October 1, 2003 through September 30, 2004**

I, Peter B. Davidson, am associated with the firm PricewaterhouseCoopers. I am a Member of the American Academy of Actuaries and meet its qualification standards to certify as to the actuarial soundness of proposed capitation rates for the period October 1, 2003 through September 30, 2004 developed for contracting managed care plans under the Oregon Medicaid program.

It is my opinion that all requirements of the Balanced Budget Act of 1997, with respect to the development of Medicaid managed care capitation rates, were satisfied in the development of the proposed capitation rates for contracting Medicaid managed care plans in Oregon. Detailed descriptions of the methodology and assumptions used in the development of the capitation rates are contained in the remainder of the report to which this actuarial certification is attached and in the November 11, 2002 report entitled "Analysis of Federal Fiscal Years 2004 – 2005 Average Costs."

In the development of the proposed capitation rates, I relied on enrollment, encounter, and other data provided by the Oregon Office of Medical Assistance Programs. I reviewed the data for reasonableness; however, I performed no independent verification and take no responsibility as to the accuracy of these data.

The actuarially sound rates shown in the accompanying report are a projection of future events. It may be expected that actual experience will vary from the values shown here. Actuarial methods, considerations, and analyses used in developing the proposed capitation rates conform to the appropriate Standards of Practice promulgated from time to time by the Actuarial Standards Board.

The capitation rates may not be appropriate for any specific health plan. Any health plan will need to review the rates in relation to the benefits provided. The health plan should compare the rates with their own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with the State. The health plan may require rates above, equal to, or below the actuarially sound capitation rates in this report.

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Peter B. Davidson, M.A.A.A  
Member, American Academy of Actuaries

**Oregon Health Plan**  
**Summary Calculation of Capitation Rates for**  
**October 2003 – September 2004**

**PricewaterhouseCoopers LLP**  
**September 2003**

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**Oregon Health Plan**  
**Summary Calculation of Capitation Rates for**  
**October 2003 – September 2004**

**PricewaterhouseCoopers LLP**  
**September 2003**

The following report presents the methods used to develop the capitation rates to be paid to Fully Capitated Health Plans, Mental Health Organizations, Dental Care Organizations, and Chemical Dependency Organizations participating in the Oregon Health Plan Medicaid Demonstration for the year beginning October 1, 2003.

These methods are designed to comply with:

- 1) The requirements of new regulations issued by the Centers for Medicare and Medicaid Services (CMS) governing the development of capitation payments for Medicaid managed care programs, and.
- 2) Relevant Oregon statutory requirements

The capitation rates shown in this report also include children covered under Title XXI. This report is a follow-up to our detailed report on total 2004-2005 biennial per capita costs for the program dated November 11, 2002, and provides a description of the specific methods used to develop plan-specific capitation rates from the per capita costs.

## I. Governing Regulations

PricewaterhouseCoopers LLP (PwC) calculated capitation rates for the Oregon Health Plan for the period October 1, 2003 through September 30, 2004. In a significant change from prior years, CMS issued new regulations governing the development of capitation payments for Medicaid managed care programs. These new regulations require that rates be “actuarially sound.” While there are no definitive criteria for determining actuarial soundness for Medicaid managed care programs, CMS has issued a checklist that provides guidance. We have followed that checklist in developing the proposed rates shown here and Exhibit A-2 in the Appendix shows where checklist items have been addressed in the reports. Certain checklist items, not appropriate for inclusion in the body of this report and not addressed in our November 2002 report on 2004-2005 biennial per capita costs, have been addressed in the Appendix Exhibit A-3.

The final rates will be established through signed contracts with the participating managed care plans, which will ensure that the plan concurs that the rates paid will allow for contracting with sufficient numbers of providers to ensure appropriate access to health care, and that they expect to remain financially sound throughout the contract period.

The general guidelines for developing actuarially sound payment rates encompass the following concepts:

- Data appropriate for the population to be covered by the managed care program should be used for the analysis;
- Payment rates should be sufficiently differentiated to reflect known variation in per capita costs related to age, gender, Medicaid eligibility category, and health status;
- Where rate cells have relatively small numbers of individuals, cost neutral data smoothing techniques should be used;
- Medicaid fee-for-service (FFS) payment rates per unit of service are an appropriate benchmark for developing capitation rates;

- When FFS data are used for the calculations, differences in expected utilization rates between fee-for-service and managed care programs should be accounted for;
- Appropriate levels of health plan administrative costs should be included in the rates;
- Programmatic changes in the Medicaid program between the data and contract period should be reflected in the rates; and
- A range of appropriate rates could emerge from the rate-setting process, and an upper and lower bound may be developed.

These rates are developed to be consistent with the concepts described above. The development of the rates is described in this report and the supporting calculations are shown in the attached exhibits.

In addition to CMS guidelines, Oregon law is considered in developing the payment rates. When the base per capita costs were developed in November 2002 the rates were calculated under the expectations of Senate Bill 27, that “rates cover the cost of providing services.” A thorough description of the methods employed to meet those requirements is provided in our November 2002 report. Oregon House Bills 2511 and 3624 overturned this provision of SB27.

## **II. Contracting Arrangements**

The Oregon Health Plan contracts with a number of different types of organizations for portions of the health care service package. Fully Capitated Health Plans, or FCHPs, contract for nearly the full range of physical health care services, including inpatient, outpatient, physician, prescription drug, and miscellaneous medical services. FCHPs may also contract for maternity management, an optional service. Mental Health Organizations, or MHOs, contract to provide inpatient and outpatient therapy services on a capitated basis. Dental Care Organizations contract to provide dental services, and Chemical Dependency Organizations contract to provide substance abuse services. Within each general category of service (e.g., mental health) an organization is contracted for the full range of capitated services.

The capitation rates shown in this report represent the amounts to be paid to contracting plans. For FCHPs, MHOs, and CDOs separate capitation rates have been calculated for each plan, region and eligibility category. Capitation rates for DCOs vary by region and eligibility category only.

The twelve eligibility categories and five geographic regions for which capitation rates are calculated are as follows:

<b>OHP Eligibility Categories</b>	
Temporary Assistance to Needy Families (TANF)	OHP Families
PLM Adults	OHP Adults & Couples
PLM, TANF, and CHIP Children Aged 0 < 1	AB/AD with Medicare
PLM, TANF, and CHIP Children Aged 1 – 5	AB/AD without Medicare
PLM, TANF, and CHIP Children Aged 6 – 18	OAA with Medicare
SCF Children	OAA without Medicare

<b>OHP Geographic Regions</b>
Jackson, Josephine and Douglas Counties
Lane County
Linn, Benton, Marion, Polk and Yamhill Counties
Other
Tri-County (Clackamas, Multnomah and Washington Counties)

Effective February 1, 2003 the General Assistance eligibility category was eliminated. Most of these individuals will continue to qualify for Medicaid under AB/AD without Medicare. We blended the per capita costs for AB/AD without Medicare and GA to produce the statewide capitation rates for AB/AD without Medicare, which are used in the plan capitation rate development.

### **III. Statewide Average Capitation Rates**

Capitation rates for each plan are based on statewide average capitation rates with adjustments for geographic areas, risk adjustment results, and covered benefit levels, where appropriate. To calculate the capitation rates for the program, we begin with the per capita costs calculated for managed care enrollees shown in Exhibit 7-A of our November 2002 report. Exhibit 1 of this report shows the categories of service that are covered under the FCHP, DCO, MHO, and CDO capitation contracts, respectively.

#### **Prioritized List of Services**

The per capita costs for managed care enrollees calculated in our November 2002 report are based on health plan encounter data covering services through the equivalent of line 557 of the prioritized list as configured for the 2003-2005 biennium. Subsequent to the issuance of that report, a request to reduce the coverage level by eight lines on the 2001-03 list was approved by CMS. We worked with the Oregon Health Services Commission to understand and evaluate the effect of these changes on the 2003-05 Prioritized List. An adjustment was applied to the per capita costs to reflect the reduction in coverage. The factors to adjust the per capita costs from coverage to line 557 to coverage to line 549 are shown in Exhibit 2a.

#### **Trend Adjustment**

The per capita costs developed in our November 2002 report were calculated to cover the two year time period of October 2003 through September 2005. The capitation rates developed in this report cover the one-year period of October 2003 through September 2004.

Trend adjustments for FCHPs and CDOs are calculated using the trending methodology that has been used in prior capitation rate developments. Specifically, the trend rates that were applied in the per capita cost

development for the biennium are adjusted to move the projected costs from the midpoint of the biennium (October 1, 2004) to the midpoint of the contract period (April 1, 2004).

For MHOs and DCOs, the capitation rates are paid for the entire biennium, without separate trend adjustments for the first and second years.

### **Maternity Case Rate**

Beginning October 1, 2003, OMAP will pay a case rate in lieu of the portion of the capitation payment attributable to maternity-related services. The case rate will cover prenatal care, professional services related to pregnancy and delivery, and hospital services arising from the delivery. Payment will be made to the plan upon completion of the pregnancy. PwC developed the statewide maternity case rate to be actuarially equivalent to the per capita funding for maternity-related services. The maternity case rate is uniform for all eligibility categories and varies by FCHP only for differences in geographic input costs. The statewide capitation rates have been adjusted to exclude the professional and hospital maternity components. The development of the maternity case rates is shown in Exhibit 2b.

### **Changes in Underlying Provider Reimbursement**

Similar to most other states, Oregon is experiencing severe budget pressures. In its 2003 session, the State Legislature passed a budget, which included an approximately 24% reduction in the funding for Medicaid managed care hospital costs relative to the costs developed in our November 2002 per capita cost report. Separate legislation was passed that stipulated the payment terms for hospitals that do not contract with managed care plans. The legislation was designed to ensure that health plans are able to contract with a sufficient number of hospitals to secure appropriate levels of access to care. Hospitals that do not enter into contracts with health plans will receive payment that is 7.5% lower than the amount included in the capitation rates for hospital services.

The funding for hospitals classified as A and B (generally smaller, rural hospitals critical for maintaining access to care for Medicaid recipients) remains unchanged due to statutory requirements to fund these hospitals at cost. Therefore, the reduction in funding is drawn entirely from what are classified as DRG hospitals (larger, often urban hospitals paid on a DRG

basis). A reduction of 28% in funding for the DRG hospitals was calculated to result in a 24% reduction in funding for all hospitals.

### **Changes in Covered Services**

Effective October 1, 2003, certain prescription drugs that have been covered on a FFS basis will become the responsibility of the FCHPs and covered under their capitation payment. The change relates to the status of certain drugs that were incorrectly classified under therapeutic classes 7 or 11, and therefore not considered FCHP responsibility. These drugs were placed on a “frozen drug list” until the opportunity to make the correction was available. PwC analyzed the FFS prescription drug data and calculated an adjustment to the FCHP capitation rates that reflects the additional managed care cost of these drugs. The statewide per capita value of the “frozen drugs” can be found in Exhibit 2c.

Under the Oregon Health Plan waiver revision of October 2002 (OHP2), the OHP Families and OHP Adults/Couples (called the OHP Standard population) populations are subject to cost sharing requirements. Additionally, the scope of benefits for this population was reduced. Exhibit 2d provides a summary of the covered services and cost sharing requirements for the OHP Standard population. Adjustments to the average costs and capitation rates were made to reflect benefit differences and expected morbidity differences. The development of the OHP Standard capitation rates is explained in more detail in the following section.

### **Pricing the OHP Standard Benefit**

To calculate the expected cost for the OHP Standard population, we undertook the following analysis:

1. The per capita costs developed in our November 2002 report were used as the starting point, including assumptions regarding underlying utilization rates and unit costs.
2. For each service category, we calculated the per member per month value of the cost sharing requirements and the adjustments to covered services. These calculations were made separately for each delivery system, service category, and eligibility category combination. The per member per month value of cost sharing and

non-covered services were ultimately converted to percentage values.

3. A utilization adjustment for each service category was developed reflecting the expected changes in utilization that would result from new or higher cost sharing requirements. These utilization adjustments were derived from a PwC actuarial pricing model with consideration of the behavioral effects of cost sharing for individuals with reduced income levels. The utilization adjustment factors are shown in the following table:

<b>OHP STANDARD UTILIZATION ADJUSTMENTS BY SERVICE CATEGORY</b>	
<b>SERVICE CATEGORY</b>	<b>ADJUSTMENT</b>
All Outpatient other than Emergency Room	0.99
Emergency Room	0.70
Diagnostic X-ray	0.98
Lab	0.93
DME/Supplies (Where covered)	0.99
Physician Office Visits	0.94
Prescription Drugs Basic	0.90

4. Each of these adjustment factors was applied to the base per capita cost calculations.
5. The remaining adjustments including trend, changes in prioritized list coverage, provider reimbursement, and covered services were applied.

### **Hysterectomy/Sterilization Recoupments**

OMAP recoups from FCHPs a fixed dollar amount for hysterectomies and sterilizations that do not meet the required consent and documentation criteria. The amount to be recouped from health plans will be determined through a separate analysis.

<b>Hysterectomy/Sterilization Recoupment</b>	
<b>SERVICE</b>	<b>RECOUPMENT</b>
Hysterectomy	\$5,090
Sterilization – Female	\$1,431
Sterilization – Male	\$467

### **Administration Cost Allowance**

An administration cost allowance of 8% is included in all of the capitation rates. This amount is intended to cover the costs of administering a mature managed care program that already has information systems in place. Additional costs associated with plan start-up or with marketing individual plans are not intended to be covered by the 8% administrative cost allowance. We reviewed plan financial reports and confirmed that, on average, reported administrative costs ranged around 8%.

For the OHP Standard capitation rates, the amount of the administration allowance was calculated considering the net per capita cost plus the per capita costs for copayments, since plan administration costs do not decline with the introduction of copayments.

### **Statewide Average Capitation Rates**

Exhibit 2e shows the statewide average capitation rates that result from the above adjustments, and which form the basis of the plan-specific rates. Several adjustments are made to the statewide average capitation rates to develop the plan-specific capitation rates. These adjustments are described in the following sections. Exhibit 2f shows, by eligibility group, the adjustment factors that are applied to the statewide capitation rates for each service category.

## **IV. Plan-Specific FCHP Capitation Rates**

Capitation rates for FCHPs are based on the statewide average capitation rates for each eligibility category, modified for certain plan-specific features, including geographic coverage area, Chronic Illness and Disability Payment System (CDPS) score, and methadone treatment prevalence. The statewide

capitation rate for each service is multiplied by the plan-specific geographic factor and then multiplied by the applicable risk adjustment factor to arrive at the capitation rate to be paid to that plan for the given service. The resulting costs are summed across all services included in the contract and then increased for administrative cost to arrive at the final capitation rate.

In the development of each of the adjustment factors described in this report, plan configurations and service areas known as of June 30, 2003 are used. In situations where members of a managed care plan were or will be assumed by a new plan, these calculations have transferred data for all affected members to the new plan. In situations where a plan has exited all or part of a service area and members are in fee-for-service, those members have been included in these calculations, but not allocated to a plan.

The methodology described here generates capitation rates for each combination of FCHP, region, and eligibility category; due to this large volume of rates, this report includes statewide average capitation rates as well as the plan-specific factors that are used to develop the rates for each plan. The detailed calculation of final rates for each plan will be distributed to each FCHP individually; a summary of these rates and a comparison to Federal Fiscal Year 2003 (FFY2003) levels is shown in the Exhibit 3e.

## **Geographic Adjustments**

The starting average capitation rate is based on data for the entire state. Geographic adjustment factors are used to reflect known differences in input costs for different geographic locations. Additionally, the geographic factors recognize differences in case mix for inpatient hospital services for individuals who travel outside of their local service area.

Geographic factors for hospital inpatient and outpatient services are calculated on a plan-specific basis. Oregon law requires Type A and B hospitals be paid at their individual facility cost unless otherwise negotiated between the plan and hospital, and this methodology is designed to allow compliance with that requirement. It is OMAP policy to ensure that capitation rates are adequate to allow this payment level.

Since maternity services will be paid on a case rate basis in FY 2004, separate geographic factors were developed for maternity and non-maternity services. The non-maternity geographic factors are applied to the non-

maternity hospital services to develop the plan-specific capitation rates. The maternity geographic factors are used in the development of the plan-specific maternity case rates.

To develop geographic factors for inpatient hospital services, the following calculations were performed:

1. An analysis of hospital claims data showed that out-of-area hospital admissions often exhibit higher case mix and related higher cost per day than in-area admissions. Consequently, an algorithm was applied to segregate these admissions in instances where cost differences would be expected. Out-of-Area admissions were defined as any admission to a hospital located more than 75 miles from the patient's residence, with the following exceptions:
  - For Tri-County residents, all admissions are designated as In-Area,
  - For all A and B hospitals, all admissions are considered In-Area,
  - Out of state hospitals are not considered in the calculations, and
  - For Coos and Douglas counties, the Out-of-Area threshold is 50 miles from the patient's residence;
2. The distance between a patient's residence and the hospital to which they were admitted was calculated using "geo mapping" software. Specific home addresses were unavailable so the centroid of the residence zip code was used;
3. Admissions with reported room and board unit totals that differed substantially from the length of stay calculated using admission and discharge dates were excluded;
4. Each admission was determined to be In-Area or Out-of-Area based on the criteria described above;

5. The average cost per day at each hospital was calculated based on FY 1999 Medicaid hospital cost reports. Each hospital was identified as being a Type A, a Type B, a Type C, or a DRG hospital. Type C hospitals are not Type A or Type B hospitals, are located in remote areas greater than 60 miles from the nearest acute care hospital, receive graduate medical education payments for their Medicaid fee-for-service admissions directly from OMAP, and are generally treated as DRG hospitals. For development of the geographic factors, the only hospital identified as Type C was Merle West Medical Center. All average costs per day for DRG hospitals were reduced by 28% due to the changes in underlying provider reimbursement described earlier;
6. Each hospital was assigned a cost per day value. For Type A and Type B hospitals the detailed information from the 1999 cost reports was used to determine the value. For DRG hospitals the value was determined based on the statewide average cost per day for all DRG hospitals multiplied by a geographic factor calculated using CMS Diagnosis Related Group payment factors. A separate calculation is made for Merle West hospital to recognize the teaching costs associated with that hospital. The CMS DRG factors have been updated using Oregon specific factors to be in effect for FY 2004;
7. For each hospital, we calculated In-Area, Out-of-Area, and Average billed charges per day using the billed charges, day counts, and the area designation for each admission. We also calculated the distribution of days between In-Area and Out-of-Area;
8. For each hospital, we calculated In-Area and Out-of-Area costs per day using the hospital's cost per day from step 6 and the ratio of the In-Area and Out-of-Area billed charges per day to the Average billed charges per day [for example, the hospital-specific In-Area cost per day = hospital-specific cost per day x hospital-specific In-Area billed charge per day / hospital-specific Average billed charge per day];

9. For each county of residence, we calculated the average cost per day using the In-Area/Out-of-Area distribution of patient days to each hospital by residents of the county and the calculated In-Area or Out-of-Area costs per day for each hospital;
10. For each FCHP, we determined the distribution of members by county as of June 30, 2003;
11. For each FCHP and region, we calculated the average cost per day using the distribution of members by county and the county average cost per day; and
12. For each FCHP and region, we calculated the relative cost per day by dividing the results from step 11 by the statewide average cost per day.

The process of calculating geographic factors for outpatient hospital services follows the same general procedure as described above for inpatient services, with two important differences. First, while inpatient services use the average cost per day from the Medicare hospital cost reports, a corresponding meaningful measure is not available from this source for outpatient services. Consequently, alternate sources are required to calculate these values; health plan encounter data are instead used to calculate the average outpatient charges per claim for each hospital. These charges are then applied against the cost-to-charge ratio developed in the Medicaid cost reports to arrive at the average cost per claim for each hospital, analogous to the cost per day described in step 5 above. Second, no distinction is made between in- and out-of-area visits for the outpatient hospital factor calculation. Lab and x-ray services provided in an outpatient hospital setting are excluded from the calculations.

The calculation of the outpatient cost per claim includes a corridor of  $\pm 25\%$  around the statewide average cost per claim for DRG hospitals. If the cost for a given hospital is outside that allowable corridor, the cost per claim for that hospital is reset to the  $\pm 25\%$  limit. This adjustment is included to reduce volatility in the Outpatient geographic factors and to mitigate the difference in the types of outpatient services delivered at hospitals in various areas of the state.

The inpatient and outpatient geographic factors resulting from the above process are shown for each plan and region in Exhibit 3a.

### **Chronic Illness and Disability Payment System Risk Adjustment**

The Chronic Illness and Disability Payment System risk adjustment methodology is used to calculate risk adjustment scores for the TANF, OHP Adults & Couples, OHP Families, Children 1-5, Children 6-18, and AB/AD without Medicare groups. Due to concerns about the incompleteness of encounters for Medicaid recipients who are eligible for both Medicare and Medicaid (Dual Eligibles), particularly for encounters for which Medicare would pay the entire amount, the risk adjustment scores calculated for AB/AD with Medicare and OAA with Medicare were not applied. For AB/AD with Medicare, the risk adjustment scores for AB/AD without Medicare were used to adjust the capitation rates. For OAA without Medicare eligibility group, no risk adjustment was applied since the small size of the population results in non-credible CDPS scores.

For the Children 0-1 category, an adjustment (described below under “Newborn Adjustment”) considering the relative propensity of plans to enroll infants at birth, and thus be responsible for initial, often expensive, service costs was developed. It was felt that for this population this adjustment more appropriately reflected expected cost differences between plans than the CDPS risk adjustment. Therefore, no CDPS risk adjustment was applied.

The CDPS system uses an array of 66 disease categories along with projected cost factors for each to evaluate the relative risk experienced among health plans.

For FFY2004 we applied CDPS version 2.0. This version of CDPS incorporates:

- Virtually all current and former diagnosis codes in the ICD-9 coding system;
- Elimination of lab and radiology claims from the CDPS risk profile. This helps avoid the generation of CDPS indicators by “rule-out” diagnoses commonly coded on lab and radiology claims;

- Imposition of a 3-month minimum length of OHP eligibility in order for an individual to be included in the calculation; and
- No weight assigned to pregnancy related indicators to accommodate the removal of the maternity portion of the capitation rates.

Data used for this analysis include encounter data and FFS data provided by OMAP covering October 2000 through September 2002 dates of service. Separate calculations are performed for the period October 2000 – September 2001 (first year) and the period October 2001 – September 2002 (second year). The first and second year scores are then averaged to produce a final score. The purpose of the two-year calculation is to reduce the volatility of risk scores, particularly for the smaller plans.

The FFS and encounter data are combined and classified into the disease categories specified in the CDPS, using all ICD9 codes recorded on each claim. Information is then summarized by person to establish a “risk profile” for each member. This risk profile shows the complete health information for each person and is not impacted by health plan or whether claims were incurred in the fee-for-service system or under managed care.

Since some members move between eligibility categories, the next step in our analysis is to allocate each enrollee’s expected cost, as a function of his or her disease history, to the various aid groups in which he or she was enrolled. This allocation is done using the proportion of the individual’s total months of enrollment spent under each aid group. Using these member month weights, a person’s risk profile is allocated to each aid category.

The CDPS scores that result from this process show variation between plans that may not be due solely to health status of enrolled members, but may also be attributable to data issues, such as under-reporting of encounters from capitated providers. For this reason, OMAP has implemented a floor of 0.85 on calculated risk adjustment scores. To implement this corridor, the scores of those plans that are below 0.85 are moved to the corridor value and the other plans’ scores are adjusted by a factor such that the weighted average of all plans’ scores equals 1.0. Exhibit 3b shows the final CDPS scores after application of the 0.85 floor.

## **Chemical Dependency Risk Adjustment**

The distribution of chemical dependency services throughout the state of Oregon is not uniform; Methadone clinics are primarily found in urban settings and members requiring treatment have a tendency to move to the area in which services are available. Within a geographic area, chemical dependency usage has also been shown to be non-uniform across plans. Risk adjustment factors were calculated for each plan, region, and eligibility category. These factors are calculated as follows:

1. Methadone months of treatment are summarized by plan, region and eligibility category using encounter data for the period October 1, 2001 – September 30, 2002.
2. These treatment months are divided by corresponding member months of eligibility to determine a Methadone rate per 1,000 members.
3. Using TANF as an example, Methadone relative prevalence factors are developed for each plan by dividing each plan/region's TANF rate/1,000 by the overall average TANF rate/1,000. Similar calculations are done for each eligibility category.
4. Step 3 results in a relative factor of 0.00 for plans that have historically not had any members receiving Methadone treatment. To accommodate the chance that a small number of Methadone patients will occur in these plans during FFY2002, a floor of 2% is applied to each plan's score. The remaining plan scores are then normalized so that the average score across all plans is 1.0.
5. The Methadone utilization factors are applied to the Chemical Dependency – Methadone service category. Other Chemical Dependency service categories receive the CDPS risk adjustment. The Methadone and CDPS factors are blended using the portion of Chemical Dependency costs related to each service category as developed in our November 2002 per capita cost report. The resulting Chemical Dependency adjustment factors are shown in Exhibit 3c.

## **Newborn Adjustment**

As mentioned above, the Newborn Adjustment is applied to the statewide average capitation rates for Children 0-1 to adjust for the relative propensity of plans to enroll infants at birth. Since the first days of an infant's life tend to be relatively expensive and since infants not born into a plan cannot be enrolled until after they are discharged from the hospital, the enrollment differences can have a significant effect on the expected cost to each plan.

We calculated the relative per capita cost for infants born into a plan versus those who were not, and found that infants born into plans were approximately 2.8 times as expensive on a per capita basis as those who were not. We then calculated the historical member month distribution by plan between infants born into and not born into plans, and used the aforementioned cost relationship to calculate adjustment factors for each plan. These factors are shown in Exhibit 3d, and are applied in lieu of CDPS risk adjustments for the Children 0-1 eligibility category.

### **Optional Services**

Maternity management is an optional responsibility for FCHPs; those choosing to provide maternity management receive an additional capitation amount that varies by eligibility category. Cascade Comprehensive Care is the only plan that elected to provide the optional maternity management service for FFY2004.

### **Plan-Specific FCHP Capitation Rates**

The plan-specific FCHP capitation rates calculated using the statewide average capitation rates from Exhibit 2e and the adjustments described above are shown in Exhibit 3e. This exhibit also shows comparisons to the FY 2003 capitation rates. It should be noted that the composition of certain eligibility categories (e.g., the TANF eligibility category for FY 2004 is composed of only TANF adults, whereas in FY 2003 it included children) have changed significantly. These changes are noted on the exhibit.

## **V. Plan-Specific MHO Capitation Rates**

Similar to the process described above for FCHPs, MHO capitation rates are based on statewide average rates, adjusted for geographic differences. Additionally, the SCF Child group receives an additional adjustment

reflecting the disproportionate enrollment between plans of above average cost children living in residential medical facilities.

Final capitation rates for FFY2004 and a comparison to FFY2003 rates are shown in the Appendix; detailed rate calculations will be distributed to each MHO individually.

### **Geographic Adjustments**

MHOs receive geographic adjustments to the Acute Inpatient category only; all other services are paid based on the statewide average cost of services. The adjustment factors for MHO inpatient services are calculated in a similar method to that described in Section III for FCHP inpatient services. MHO encounter data are used for the analysis of hospital use.

MHO enrollment as of June 2003 is examined in place of FCHP enrollment to determine enrollment by plan and zip code. MHO members' zip codes of residence are matched to the encounter patient flow information to calculate the average cost per day for members enrolled in each MHO. Relative cost factors, shown in Exhibit 4a, are then calculated by comparing each plan's cost/day to the average cost/day for all MHOs.

### **SCF Residential Medical Adjustment**

The SCF category includes some children who reside in Residential Medical facilities and have costs significantly higher than the average SCF Child rate. The statewide average capitation rate includes the cost of these children. To appropriately distribute the capitation amount for this category to each plan, risk adjustment factors are calculated that reflect the relative prevalence of these children and their additional expected cost in each plan. Plans with a higher than average proportion of Residential Medical children have adjustment factors that are greater than 1.0; plans with a below-average proportion of these children have factors less than 1.0. The adjustment factors for each plan and region are shown in Exhibit 4b.

### **Plan-Specific MHO Capitation Rates**

The plan-specific MHO capitation rates calculated using the statewide average capitation rates from Exhibit 2e and the adjustments described above are shown in Exhibit 4c. This exhibit also shows comparisons to the FY 2003 capitation rates.

## VI. DCO Capitation Rates

### Geographic Adjustments

DCO capitation rates vary by geographic region of the state, but do not vary by plan. The geographic factors are updated for each biennium and are constant for the biennium. The geographic factor calculation is based upon the Medicare RBRVS geographic adjustment factors for Oregon that take into account the component costs of professional services. The adjustment uses the FY 2003 Oregon RBRVS factors weighted by the population distribution. These DCO geographic factors are as follows:

<b>Geographic Area</b>	<b>Geographic Factor</b>
Jackson, Josephine and Douglas Counties	0.9658
Lane County	0.9658
Linn, Benton, Marion, Polk and Yamhill Counties	0.9658
Other	0.9658
Tri-County (Clackamas, Multnomah and Washington Counties)	1.0513

### Region-Specific DCO Capitation Rates

The region-specific DCO capitation rates calculated using the statewide average capitation rates from Exhibit 2e and the adjustments described above are shown in Exhibit 5. This exhibit also shows comparisons to the FY 2003 capitation rates.

## VII. Plan-Specific CDO Capitation Rates

There is one CDO in operation, in Deschutes County. This plan serves as a chemical dependency “carve out” plan, covering all chemical dependency services in that county for FCHP members. The FCHP in that county is not capitated for these costs.

CDO capitation rates are calculated as the statewide average chemical dependency cost by eligibility category, multiplied by that area’s chemical

dependency risk adjustment factor, calculated according to the methodology described above in Section III. The resulting CDO capitation rates are shown in Exhibit 6, along with comparisons to the FY 2003 capitation rates.

**Oregon Health Plan Medicaid Demonstration  
 FY2004 Capitation Rates  
 FCHP, DCO, MHO and CDO Capitated Services**

**Exhibit 1**

Detail Service Category	Rate Sheet Category	FCHP Capitation	DCO Capitation	MHO Capitation	CDO Capitation
<b>PHYSICAL HEALTH</b>					
ANESTHESIA	Physician - Basic	Mandatory			
EXCEPT NEEDS CARE COORDINATION	Exceptional Needs Care Coordination	Mandatory			
FP - IP HOSP	Inpatient - Family Planning	Mandatory			
FP - OP HOSP	Outpatient - Family Planning	Mandatory			
FP - PHYS	Physician - Family Planning	Mandatory			
HYSTERECTOMY - ANESTHESIA	Physician - Hysterectomy	Mandatory			
HYSTERECTOMY - IP HOSP	Inpatient - Hysterectomy	Mandatory			
HYSTERECTOMY - OP HOSP	Outpatient - Hysterectomy	Mandatory			
HYSTERECTOMY - PHYS	Physician - Hysterectomy	Mandatory			
IP HOSP - ACUTE DETOX	Inpatient - Basic	Mandatory			
IP HOSP - MATERNITY	Inpatient - Maternity	Mandatory			
IP HOSP - MEDICAL/SURGICAL	Inpatient - Basic	Mandatory			
IP HOSP - NEWBORN	Inpatient - Newborn	Mandatory			
LAB & RAD - DIAGNOSTIC X-RAY	Physician - Basic	Mandatory			
LAB & RAD - LAB	Physician - Basic	Mandatory			
LAB & RAD - THERAPEUTIC X-RAY	Physician - Basic	Mandatory			
OP ER - SOMATIC MH	Outpatient - Emergency Room	Mandatory			
OP HOSP - BASIC	Outpatient - Basic	Mandatory			
OP HOSP - EMERGENCY ROOM	Outpatient - Emergency Room	Mandatory			
OP HOSP - LAB & RAD	Outpatient - Basic	Mandatory			
OP HOSP - MATERNITY	Outpatient - Maternity	Mandatory			
OP HOSP - SOMATIC MH	Outpatient - Basic	Mandatory			
OTH MED - DME	Dme/Supplies	Mandatory			
OTH MED - HHC/PDN	Home Health/Pdn/Hospice	Mandatory			
OTH MED - HOSPICE	Home Health/Pdn/Hospice	Mandatory			
OTH MED - MATERNITY MGT	Maternity Management	Optional			
OTH MED - SUPPLIES	Dme/Supplies	Mandatory			

**Oregon Health Plan Medicaid Demonstration  
 FY2004 Capitation Rates  
 FCHP, DCO, MHO and CDO Capitated Services**

**Exhibit 1**

Detail Service Category	Rate Sheet Category	FCHP Capitation	DCO Capitation	MHO Capitation	CDO Capitation
<b>PHYSICAL HEALTH</b>					
PHYS CONSULTATION, IP & ER VISITS	Physician - Basic	Mandatory			
PHYS HOME OR LONG-TERM CARE VISITS	Physician - Basic	Mandatory			
PHYS MATERNITY	Physician - Maternity	Mandatory			
PHYS NEWBORN	Physician - Newborn	Mandatory			
PHYS OFFICE VISITS	Physician - Basic	Mandatory			
PHYS OTHER	Physician - Basic	Mandatory			
PHYS SOMATIC MH	Physician - Basic	Mandatory			
POST - HOSP EXTENDED CARE	Inpatient - Basic	Mandatory			
PRES DRUGS - BASIC	Prescription Drugs - Basic	Mandatory			
PRES DRUGS - FP	Prescription Drugs - Family Planning	Mandatory			
PRES DRUGS - NEURONTIN	Prescription Drugs - Basic	Mandatory			
PRES DRUGS - OP HOSP BASIC	Prescription Drugs - Basic	Mandatory			
PRES DRUGS - OP HOSP FP	Prescription Drugs - Family Planning	Mandatory			
PRES DRUGS - OP HOSP MH/CD	Prescription Drugs - Basic	Mandatory			
PRES DRUGS - TOBACCO CESSATION	Prescription Drugs - Basic	Mandatory			
STERILIZATION - ANESTHESIA	Physician - Sterilization	Mandatory			
STERILIZATION - IP HOSP	Inpatient - Sterilization	Mandatory			
STERILIZATION - OP HOSP	Outpatient - Sterilization	Mandatory			
STERILIZATION - PHY	Physician - Sterilization	Mandatory			
SURGERY	Physician - Basic	Mandatory			
TOBACCO CES-IP HSP	Inpatient - Basic	Mandatory			
TOBACCO CES-OP HSP	Outpatient - Basic	Mandatory			
TOBACCO CES-PHYS	Physician - Basic	Mandatory			
TRANSPORTATION - AMBULANCE	Transportation - Ambulance	Mandatory			
VISION CARE - EXAMS & THERAPY	Vision	Mandatory			
VISION CARE - MATERIALS & FITTING	Vision	Mandatory			

**Oregon Health Plan Medicaid Demonstration  
 FY2004 Capitation Rates  
 FCHP, DCO, MHO and CDO Capitated Services**

**Exhibit 1**

Detail Service Category	Rate Sheet Category	FCHP Capitation	DCO Capitation	MHO Capitation	CDO Capitation
<b>DENTAL</b>					
DENTAL - ADJUNCTIVE GENERAL	Dental		Mandatory		
DENTAL - ANESTHESIA SURGICAL	Dental		Mandatory		
DENTAL - DIAGNOSTIC	Dental		Mandatory		
DENTAL - ENDODONTICS	Dental		Mandatory		
DENTAL - I/P FIXED	Dental		Mandatory		
DENTAL - MAXILLOFACIAL PROS	Dental		Mandatory		
DENTAL - ORAL SURGERY	Dental		Mandatory		
DENTAL - ORTHODONTICS	Dental		Mandatory		
DENTAL - PERIODONTICS	Dental		Mandatory		
DENTAL - PREVENTIVE	Dental		Mandatory		
DENTAL - PROS REMOVABLE	Dental		Mandatory		
DENTAL - RESTORATIVE	Dental		Mandatory		
DENTAL - TOBACCO CES	Dental		Mandatory		
<b>CHEMICAL DEPENDENCY</b>					
CD SERVICES - ALTERNATIVE TO DETOX	Chemical Dependency	Mandatory			Mandatory
CD SERVICES - METHADONE	Chemical Dependency	Mandatory			Mandatory
CD SERVICES - OP	Chemical Dependency	Mandatory			Mandatory
<b>MENTAL HEALTH</b>					
MH SERVICES ACUTE INPATIENT	Mh Services Acute Inpatient			Mandatory	
MH SERVICES ASSESS & EVAL	Mh Services Assess & Eval			Mandatory	
MH SERVICES CASE MANAGEMENT	Mh Services Case Management			Mandatory	
MH SERVICES CONSULTATION	Mh Services Consultation			Mandatory	
MH SERVICES ANCILLARY SERVICES	Mh Services Ancillary Services			Mandatory	
MH SERVICES ALTERNATIVE TO IP	Mh Services Alternative To Ip			Mandatory	
MH SERVICES MED MANAGEMENT	Mh Services Med Management			Mandatory	
MH SERVICES FAMILY SUPPORT	Mh Services Family Support			Mandatory	
MH SERVICES OP THERAPY	Mh Services Op Therapy			Mandatory	
MH SERVICES OTHER OP	Mh Services Other Op			Mandatory	
MH SERVICES PHYS IP	Mh Services Phys Ip			Mandatory	
MH SERVICES PHYS OP	Mh Services Phys Op			Mandatory	
MH SERVICES PEO	Mh Services Peo			Mandatory	
MH SERVICES SUPPORT DAY PROGRAM	Mh Services Support Day Program			Mandatory	

Exhibits 2004  
 Cap Categories  
 10/1/2003

**Oregon Health Plan Medicaid Demonstration**

**Exhibit 2a**

**FY2004 Capitation Rates**

**Prioritized List Adjustment Factors**

**Adjustment for Move from Line 557 to Line 549 of the Prioritized List**

<b>Eligibility Category</b>	<b>Physical Health Services</b>	<b>Chemical Dependency Services</b>	<b>Mental Health Services</b>	<b>Dental Services</b>
TANF Adults	0.9925	1.0000	1.0000	1.0000
PLM Adults	0.9995	1.0000	1.0000	1.0000
PLM, CHIP or TANF Children Aged 0-1	0.9943	1.0000	1.0000	1.0000
PLM, CHIP or TANF Children Aged 1-5	0.9850	1.0000	1.0000	1.0000
PLM, CHIP or TANF Children Aged 6-18	0.9836	1.0000	1.0000	1.0000
OHP Families	0.9861	1.0000	1.0000	1.0000
OHP Adults and Couples	0.9882	1.0000	1.0000	1.0000
AB/AD with Medicare	0.9933	1.0000	1.0000	1.0000
AB/AD without Medicare	0.9929	1.0000	1.0000	1.0000
OAA with Medicare	0.9944	1.0000	1.0000	1.0000
OAA without Medicare	0.9909	1.0000	1.0000	1.0000
SCF Children	0.9887	1.0000	1.0000	1.0000

**Oregon Health Plan Medicaid Demonstration  
FY2004 Capitation Rates  
Maternity Case Rate Development**

**Exhibit 2b**

FY 2004 Statewide Case Rate				Administration Allowance
IP HOSPITAL	OP HOSPITAL	MATERNIT Y	Total	
\$ 2,752.32	\$ 165.81	\$ 2,768.67	\$ 5,686.79	8%

Plan Name	Region	FY 2004 Geographic Adjustment Factors		FY 2004 Adjusted Case Rate				Total w/ Admin
		IP HOSPITAL	OP HOSPITAL	IP HOSPITAL	OP HOSPITAL	MATERNIT Y	Total	
CareOregon, Inc.	JJD	0.9420	0.9986	\$ 2,592.78	\$ 165.57	\$ 2,768.67	\$ 5,527.01	\$ 6,007.62
CareOregon, Inc.	LBMPY	1.0240	1.0137	\$ 2,818.37	\$ 168.08	\$ 2,768.67	\$ 5,755.11	\$ 6,255.56
CareOregon, Inc.	OTHER	1.0737	1.0717	\$ 2,955.11	\$ 177.70	\$ 2,768.67	\$ 5,901.48	\$ 6,414.65
CareOregon, Inc.	Tri-County	0.9431	0.9726	\$ 2,595.78	\$ 161.26	\$ 2,768.67	\$ 5,525.70	\$ 6,006.20
Cascade Comprehensive Care, Inc.	OTHER	0.9246	0.9464	\$ 2,544.90	\$ 156.93	\$ 2,768.67	\$ 5,470.50	\$ 5,946.19
Central Oregon Independent Health Services, Inc.	OTHER	1.1906	1.0461	\$ 3,276.97	\$ 173.46	\$ 2,768.67	\$ 6,219.10	\$ 6,759.89
Douglas County Individual Practice Association	JJD	0.9609	0.9939	\$ 2,644.59	\$ 164.80	\$ 2,768.67	\$ 5,578.06	\$ 6,063.11
Doctors of the Oregon Coast South	OTHER	0.9542	1.1120	\$ 2,626.22	\$ 184.37	\$ 2,768.67	\$ 5,579.25	\$ 6,064.40
FamilyCare, Inc.	JJD	0.9221	0.9589	\$ 2,537.84	\$ 159.00	\$ 2,768.67	\$ 5,465.51	\$ 5,940.77
FamilyCare, Inc.	OTHER	1.1848	1.1580	\$ 3,261.03	\$ 192.00	\$ 2,768.67	\$ 6,221.70	\$ 6,762.72
FamilyCare, Inc.	Tri-County	0.9430	0.9727	\$ 2,595.51	\$ 161.28	\$ 2,768.67	\$ 5,525.46	\$ 6,005.93
InterCommunity Health Plans, Inc.	LBMPY	1.1246	0.9993	\$ 3,095.36	\$ 165.70	\$ 2,768.67	\$ 6,029.73	\$ 6,554.05
Lane Individual Practice Association, Inc.	LANE	0.9640	0.9888	\$ 2,653.23	\$ 163.96	\$ 2,768.67	\$ 5,585.85	\$ 6,071.58
Marion-Polk Community Health Plan	LBMPY	0.9752	1.0152	\$ 2,684.03	\$ 168.32	\$ 2,768.67	\$ 5,621.01	\$ 6,109.80
Mid-Rogue Independent Practice Association	JJD	0.9201	0.9551	\$ 2,532.34	\$ 158.36	\$ 2,768.67	\$ 5,459.37	\$ 5,934.10
Oregon Health Management Services	JJD	0.9208	0.9563	\$ 2,534.21	\$ 158.57	\$ 2,768.67	\$ 5,461.45	\$ 5,936.36
Providence Health Plan, Inc.	LBMPY	1.2759	1.0080	\$ 3,511.60	\$ 167.13	\$ 2,768.67	\$ 6,447.40	\$ 7,008.04
Providence Health Plan, Inc.	Tri-County	0.9435	0.9724	\$ 2,596.68	\$ 161.23	\$ 2,768.67	\$ 5,526.58	\$ 6,007.15
Tuality Health Alliance	Tri-County	0.9466	0.9737	\$ 2,605.44	\$ 161.44	\$ 2,768.67	\$ 5,535.55	\$ 6,016.90

Exhibits 2004

Mat Case Rate by Plan

10/1/2003

**Oregon Health Plan Medicaid Demonstration  
 FY2004 Capitation Rates**

**Exhibit 2c**

**Adjustment for Movement of Frozen Drugs to Managed Care Capitation Rates**

Eligibility Category	Frozen Drug Cost PMPM
TANF Adults	\$0.11
PLM Adults	\$0.08
PLM, CHIP or TANF Children Aged 0-1	\$0.01
PLM, CHIP or TANF Children Aged 1-5	\$0.03
PLM, CHIP or TANF Children Aged 6-18	\$0.02
OHP Families	\$0.07
OHP Adults and Couples	\$0.13
AB/AD with Medicare	\$0.51
AB/AD without Medicare	\$0.34
OAA with Medicare	\$0.26
OAA without Medicare	\$0.30
SCF Children	\$0.07

**Oregon Health Plan Medicaid Demonstration  
 FY2004 Capitation Rates  
 Summary of Cost Sharing and Covered Services - OHP Standard**

**Exhibit 2d**

<b>Service Category</b>	<b>Cost sharing and coverage provisions</b>
Inpatient Hospital	Covered with \$250 copay per admit
Emergency Room	Covered with \$50 copay per visit
Emergency Ambulance	Covered with \$50 copay per trip
Ambulatory Surgery, Urgent Care, Rural Health Clinics	Covered with visit copays of \$5-\$20. Copays for professional services rendered will apply.
Other Non-Emergent Outpatient Hospital	Covered with no visit copays. Copays are assigned by service groups and range from \$3-\$10 per service group per visit.
Physician Office Visits	Covered with \$5 visit copay. Copays for laboratory/radiology services, surgeries, or treatments apply in addition to the visit copay.
Laboratory and Radiology	Covered with \$3 copay per service.
Treatments and Surgeries	Covered with \$5 copay per service
Hospital Visits by a Practitioner	Covered with no copay
Non-Emergency Medical Transportation	Not covered
Routine Vision Exams	Not covered
DME and supplies	Many items not covered. Covered items subject to \$2 copay.
Indian Health and Services Provided to Native American Enrollees	Covered with no copay
Family Planning, Including Family Planning Drugs	Covered with no copay
Immunizations and Vaccinations	Majority covered with no copay.
Home Health	Covered with \$5 copay per visit.
Pharmacy - HIV / Mental Health / Oncology Drugs	Covered with \$3 copay per script.
Pharmacy - Other Brand-Name Drugs	Covered with \$15 copay per script.
Pharmacy - Other Generic Drugs	Covered with \$2 copay per script.
Mental Health Services	Not covered
Chemical Dependency Services	Not covered
Dental Services	Orthodontia, most prosthetics, and many surgical procedures not covered. Preventive services generally incur no copay. Covered services have a copay ranging from \$5-\$100. A daily out-of-pocket limit on extraction copays of \$40 and a six-month benefit limit of \$500 are applied.

**Oregon Health Plan Medicaid Demonstration  
 Statewide Capitation Rates for October 2003 through September 2004  
 With Adjustments for Funding Through Line 549 of the Prioritized List**

**Exhibit 2e**

Region: <b>Statewide</b> Rate Group: <b>TANF Adults</b>
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**Physician**

Basic	\$69.29
Family Planning	\$0.94
Hysterectomy	\$0.77
Maternity	\$0.00
Newborn	\$0.09
Sterilization	\$0.95
<b>Subtotal</b>	<b>\$72.04</b>

**Outpatient**

Basic	\$29.64
Emergency Room	\$7.53
Family Planning	\$0.04
Hysterectomy	\$0.01
Maternity	\$0.00
Sterilization	\$5.55
<b>Subtotal</b>	<b>\$42.78</b>

**Prescription Drugs**

Basic	\$49.04
Family Planning	\$1.89
<b>Subtotal</b>	<b>\$50.93</b>

**Inpatient**

Basic	\$34.37
Family Planning	\$0.00
Hysterectomy	\$2.65
Maternity	\$0.00
Newborn	\$0.00
Sterilization	\$2.81
<b>Subtotal</b>	<b>\$39.83</b>

**Miscellaneous**

Chemical Dependency	\$13.79
DME/Supplies	\$1.55
Exceptional Needs Care Coordinator	\$0.00
Home Health/PDN/Hospice	\$3.91
Transportation - Ambulance	\$3.12
Vision	\$3.61
<b>Subtotal</b>	<b>\$25.98</b>

<b>Total Basic Services</b>	<b>\$231.55</b>
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**Optional Services**

Maternity Management	\$2.14
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<b>Total Services</b>	<b>\$233.69</b>
<b>Total Services with 8% Admin</b>	<b>\$254.01</b>

**Mental Health**

Acute Inpatient	\$4.05
Assess & Eval	\$2.89
Case Management	\$0.72
Consultation	\$0.23
Ancillary Services	\$0.03
Med Management	\$1.88
Alternative to IP	\$0.24
Family Support	\$0.04
OP Therapy	\$10.86
Other OP	\$0.05
PEO	\$0.57
Phys IP	\$0.15
Phys OP	\$0.71
Support Day Program	\$0.53

<b>Total MH Services</b>	<b>\$22.93</b>
<b>Total MH Services with 8% Admin</b>	<b>\$24.93</b>

<b>Dental</b>	<b>\$27.47</b>
<b>Dental Services with 8% Admin</b>	<b>\$29.86</b>

**Oregon Health Plan Medicaid Demonstration  
 Statewide Capitation Rates for October 2003 through September 2004  
 With Adjustments for Funding Through Line 549 of the Prioritized List**

**Exhibit 2e**

Region: <b>Statewide</b> Rate Group: <b>PLM Adults</b>
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**Physician**

Basic	\$82.26
Family Planning	\$1.85
Hysterectomy	\$0.07
Maternity	\$0.00
Newborn	\$0.50
Sterilization	\$3.60
<b>Subtotal</b>	<b>\$88.28</b>

**Outpatient**

Basic	\$16.44
Emergency Room	\$3.27
Family Planning	\$0.03
Hysterectomy	\$0.00
Maternity	\$0.00
Sterilization	\$30.65
<b>Subtotal</b>	<b>\$50.39</b>

**Prescription Drugs**

Basic	\$22.26
Family Planning	\$1.97
<b>Subtotal</b>	<b>\$24.23</b>

**Inpatient**

Basic	\$9.57
Family Planning	\$0.00
Hysterectomy	\$0.37
Maternity	\$0.00
Newborn	\$0.00
Sterilization	\$16.88
<b>Subtotal</b>	<b>\$26.82</b>

**Miscellaneous**

Chemical Dependency	\$4.39
DME/Supplies	\$0.91
Exceptional Needs Care Coordinator	\$0.00
Home Health/PDN/Hospice	\$2.03
Transportation - Ambulance	\$4.51
Vision	\$2.90
<b>Subtotal</b>	<b>\$14.74</b>

<b>Total Basic Services</b>	<b>\$204.45</b>
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**Optional Services**

Maternity Management	\$14.21
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<b>Total Services</b>	<b>\$218.66</b>
<b>Total Services with 8% Admin</b>	<b>\$237.68</b>

**Mental Health**

Acute Inpatient	\$0.84
Assess & Eval	\$1.25
Case Management	\$0.16
Consultation	\$0.05
Ancillary Services	\$0.00
Med Management	\$0.20
Alternative to IP	\$0.07
Family Support	\$0.00
OP Therapy	\$2.80
Other OP	\$0.01
PEO	\$0.57
Phys IP	\$0.07
Phys OP	\$0.20
Support Day Program	\$0.08

<b>Total MH Services</b>	<b>\$6.31</b>
<b>Total MH Services with 8% Admin</b>	<b>\$6.86</b>

<b>Dental</b>	<b>\$13.92</b>
<b>Dental Services with 8% Admin</b>	<b>\$15.13</b>

**Oregon Health Plan Medicaid Demonstration  
 Statewide Capitation Rates for October 2003 through September 2004  
 With Adjustments for Funding Through Line 549 of the Prioritized List**

**Exhibit 2e**

Region: <b>Statewide</b> Rate Group: <b>PLM, CHIP, or TANF Children Aged 0-1</b>
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**Physician**

Basic	\$90.95
Family Planning	\$0.00
Hysterectomy	\$0.00
Maternity	\$0.00
Newborn	\$19.07
Sterilization	\$0.00
<b>Subtotal</b>	<b>\$110.02</b>

**Outpatient**

Basic	\$15.65
Emergency Room	\$6.37
Family Planning	\$0.00
Hysterectomy	\$0.00
Maternity	\$0.00
Sterilization	\$0.01
<b>Subtotal</b>	<b>\$22.03</b>

**Prescription Drugs**

Basic	\$11.07
Family Planning	\$0.01
<b>Subtotal</b>	<b>\$11.08</b>

**Inpatient**

Basic	\$45.90
Family Planning	\$0.00
Hysterectomy	\$0.01
Maternity	\$0.00
Newborn	\$123.80
Sterilization	\$0.00
<b>Subtotal</b>	<b>\$169.71</b>

**Miscellaneous**

Chemical Dependency	\$0.00
DME/Supplies	\$1.97
Exceptional Needs Care Coordinator	\$0.00
Home Health/PDN/Hospice	\$1.77
Transportation - Ambulance	\$4.79
Vision	\$0.29
<b>Subtotal</b>	<b>\$8.82</b>

<b>Total Basic Services</b>	<b>\$321.65</b>
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**Optional Services**

Maternity Management	\$0.00
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<b>Total Services</b>	<b>\$321.65</b>
<b>Total Services with 8% Admin</b>	<b>\$349.62</b>

**Mental Health**

Acute Inpatient	\$0.00
Assess & Eval	\$0.01
Case Management	\$0.00
Consultation	\$0.00
Ancillary Services	\$0.00
Med Management	\$0.00
Alternative to IP	\$0.00
Family Support	\$0.00
OP Therapy	\$0.02
Other OP	\$0.00
PEO	\$0.57
Phys IP	\$0.00
Phys OP	\$0.00
Support Day Program	\$0.00

<b>Total MH Services</b>	<b>\$0.61</b>
<b>Total MH Services with 8% Admin</b>	<b>\$0.66</b>

<b>Dental</b>	<b>\$0.09</b>
<b>Dental Services with 8% Admin</b>	<b>\$0.09</b>

**Oregon Health Plan Medicaid Demonstration  
 Statewide Capitation Rates for October 2003 through September 2004  
 With Adjustments for Funding Through Line 549 of the Prioritized List**

**Exhibit 2e**

Region: <b>Statewide</b> Rate Group: <b>PLM, CHIP, or TANF Children Aged 1-5</b>
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**Physician**

Basic	\$30.91
Family Planning	\$0.00
Hysterectomy	\$0.00
Maternity	\$0.00
Newborn	\$0.07
Sterilization	\$0.00
<b>Subtotal</b>	<b>\$30.98</b>

**Outpatient**

Basic	\$9.55
Emergency Room	\$3.48
Family Planning	\$0.00
Hysterectomy	\$0.00
Maternity	\$0.00
Sterilization	\$0.00
<b>Subtotal</b>	<b>\$13.04</b>

**Prescription Drugs**

Basic	\$7.82
Family Planning	\$0.01
<b>Subtotal</b>	<b>\$7.82</b>

**Inpatient**

Basic	\$8.52
Family Planning	\$0.00
Hysterectomy	\$0.00
Maternity	\$0.00
Newborn	\$0.00
Sterilization	\$0.00
<b>Subtotal</b>	<b>\$8.52</b>

**Miscellaneous**

Chemical Dependency	\$0.00
DME/Supplies	\$0.50
Exceptional Needs Care Coordinator	\$0.00
Home Health/PDN/Hospice	\$1.08
Transportation - Ambulance	\$1.08
Vision	\$0.61
<b>Subtotal</b>	<b>\$3.29</b>

<b>Total Basic Services</b>	<b>\$63.65</b>
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**Optional Services**

Maternity Management	\$0.00
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<b>Total Services</b>	<b>\$63.65</b>
<b>Total Services with 8% Admin</b>	<b>\$69.18</b>

**Mental Health**

Acute Inpatient	\$0.11
Assess & Eval	\$0.57
Case Management	\$0.21
Consultation	\$0.10
Ancillary Services	\$0.00
Med Management	\$0.06
Alternative to IP	\$0.00
Family Support	\$0.04
OP Therapy	\$1.75
Other OP	\$0.02
PEO	\$0.57
Phys IP	\$0.01
Phys OP	\$0.10
Support Day Program	\$0.61

<b>Total MH Services</b>	<b>\$4.14</b>
<b>Total MH Services with 8% Admin</b>	<b>\$4.50</b>

<b>Dental</b>	<b>\$11.97</b>
<b>Dental Services with 8% Admin</b>	<b>\$13.01</b>

**Oregon Health Plan Medicaid Demonstration  
 Statewide Capitation Rates for October 2003 through September 2004  
 With Adjustments for Funding Through Line 549 of the Prioritized List**

**Exhibit 2e**

Region: <b>Statewide</b> Rate Group: <b>PLM, CHIP, or TANF Children Aged 6-18</b>
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**Physician**

Basic	\$21.42
Family Planning	\$0.12
Hysterectomy	\$0.00
Maternity	\$0.00
Newborn	\$0.05
Sterilization	\$0.00
<b>Subtotal</b>	<b>\$21.59</b>

**Outpatient**

Basic	\$6.96
Emergency Room	\$2.22
Family Planning	\$0.01
Hysterectomy	\$0.00
Maternity	\$0.00
Sterilization	\$0.28
<b>Subtotal</b>	<b>\$9.46</b>

**Prescription Drugs**

Basic	\$9.98
Family Planning	\$0.34
<b>Subtotal</b>	<b>\$10.31</b>

**Inpatient**

Basic	\$7.14
Family Planning	\$0.00
Hysterectomy	\$0.00
Maternity	\$0.00
Newborn	\$0.00
Sterilization	\$0.00
<b>Subtotal</b>	<b>\$7.14</b>

**Miscellaneous**

Chemical Dependency	\$1.09
DME/Supplies	\$0.41
Exceptional Needs Care Coordinator	\$0.00
Home Health/PDN/Hospice	\$0.88
Transportation - Ambulance	\$0.78
Vision	\$2.79
<b>Subtotal</b>	<b>\$5.95</b>

<b>Total Basic Services</b>	<b>\$54.46</b>
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**Optional Services**

Maternity Management	\$0.16
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<b>Total Services</b>	<b>\$54.61</b>
<b>Total Services with 8% Admin</b>	<b>\$59.36</b>

**Mental Health**

Acute Inpatient	\$2.39
Assess & Eval	\$1.78
Case Management	\$0.86
Consultation	\$0.38
Ancillary Services	\$0.01
Med Management	\$0.53
Alternative to IP	\$0.16
Family Support	\$0.17
OP Therapy	\$7.79
Other OP	\$0.11
PEO	\$0.57
Phys IP	\$0.07
Phys OP	\$0.27
Support Day Program	\$1.15

<b>Total MH Services</b>	<b>\$16.24</b>
<b>Total MH Services with 8% Admin</b>	<b>\$17.65</b>

<b>Dental</b>	<b>\$17.83</b>
<b>Dental Services with 8% Admin</b>	<b>\$19.38</b>

**Oregon Health Plan Medicaid Demonstration**  
**Statewide Capitation Rates for October 2003 through September 2004**  
**With Adjustments for Funding Through Line 549 of the Prioritized List**

**Exhibit 2e**

Region: <b>Statewide</b>
Rate Group: <b>OHP Families</b>

	Cost PMPM	Copay Value	Non Covered Services Value	Behavioral Offset	Statewide Capitation Rate
<b>Physician</b>					
Basic	\$56.48	\$2.54	\$0.04	\$1.79	\$52.10
Family Planning	\$0.61	\$0.00	\$0.00	\$0.00	\$0.61
Hysterectomy	\$0.70	\$0.01	\$0.00	\$0.00	\$0.70
Maternity	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Newborn	\$0.03	\$0.00	\$0.00	\$0.00	\$0.03
Sterilization	\$0.54	\$0.00	\$0.00	\$0.00	\$0.54
<b>Subtotal</b>	<b>\$58.35</b>	<b>\$2.55</b>	<b>\$0.04</b>	<b>\$1.79</b>	<b>\$53.97</b>
<b>Outpatient</b>					
Basic	\$23.86	\$0.44	\$0.04	\$0.24	\$23.15
Emergency Room	\$4.96	\$1.27	\$0.00	\$1.49	\$2.20
Family Planning	\$0.04	\$0.00	\$0.00	\$0.00	\$0.04
Hysterectomy	\$0.03	\$0.00	\$0.00	\$0.00	\$0.03
Maternity	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Sterilization	\$1.73	\$0.04	\$0.00	\$0.02	\$1.68
<b>Subtotal</b>	<b>\$30.62</b>	<b>\$1.75</b>	<b>\$0.04</b>	<b>\$1.74</b>	<b>\$27.09</b>
<b>Prescription Drugs</b>					
Basic	\$37.43	\$4.84	\$0.00	\$3.45	\$29.14
Family Planning	\$1.71	\$0.00	\$0.00	\$0.17	\$1.54
<b>Subtotal</b>	<b>\$39.13</b>	<b>\$4.84</b>	<b>\$0.00</b>	<b>\$3.62</b>	<b>\$30.67</b>
<b>Inpatient</b>					
Basic	\$26.99	\$0.99	\$0.00	\$0.00	\$26.00
Family Planning	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Hysterectomy	\$2.25	\$0.10	\$0.00	\$0.00	\$2.15
Maternity	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Newborn	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Sterilization	\$0.28	\$0.02	\$0.00	\$0.00	\$0.25
<b>Subtotal</b>	<b>\$29.51</b>	<b>\$1.11</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$28.40</b>
<b>Miscellaneous</b>					
Chemical Dependency	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
DME/Supplies	\$1.17	\$0.00	\$0.88	\$0.01	\$0.28
Exceptional Needs Care Coordinatio	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Home Health/PDN/Hospice	\$3.27	\$0.00	\$0.01	\$0.00	\$3.25
Transportation - Ambulance	\$1.88	\$0.15	\$0.01	\$0.00	\$1.72
Vision	\$4.34	\$0.07	\$3.51	\$0.11	\$0.64
<b>Subtotal</b>	<b>\$10.65</b>	<b>\$0.22</b>	<b>\$4.42</b>	<b>\$0.13</b>	<b>\$5.89</b>
<b>Total Basic Services</b>	<b>\$168.27</b>	<b>\$10.46</b>	<b>\$4.50</b>	<b>\$7.28</b>	<b>\$146.03</b>
<b>Optional Services</b>					
Maternity Management	\$0.21	\$0.00	\$0.00	\$0.20	\$0.01
<b>Total Services</b>	<b>\$168.48</b>	<b>\$10.46</b>	<b>\$4.50</b>	<b>\$7.48</b>	<b>\$146.04</b>
<b>Administration (8% on Net Cost + Copay Value)</b>					<b>\$13.61</b>
<b>Total Services with Admin</b>					<b>\$159.65</b>

Exhibits 2004  
OHPFAM  
10/1/2003

**Oregon Health Plan Medicaid Demonstration**  
**Statewide Capitation Rates for October 2003 through September 2004**  
**With Adjustments for Funding Through Line 549 of the Prioritized List**

**Exhibit 2e**

Region: **Statewide**  
Rate Group: **OHP Adults and Couples**

	Cost PMPM	Copay Value	Non Covered Services Value	Behavioral Offset	Statewide Capitation Rate
<b>Physician</b>					
Basic	\$81.97	\$3.26	\$0.10	\$2.14	\$76.47
Family Planning	\$0.13	\$0.00	\$0.00	\$0.00	\$0.13
Hysterectomy	\$0.56	\$0.01	\$0.00	\$0.00	\$0.55
Maternity	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Newborn	\$0.05	\$0.00	\$0.00	\$0.00	\$0.05
Sterilization	\$0.09	\$0.00	\$0.00	\$0.00	\$0.09
<b>Subtotal</b>	<b>\$82.79</b>	<b>\$3.26</b>	<b>\$0.10</b>	<b>\$2.14</b>	<b>\$77.28</b>
<b>Outpatient</b>					
Basic	\$37.75	\$0.65	\$0.08	\$0.38	\$36.65
Emergency Room	\$7.94	\$1.88	\$0.00	\$2.38	\$3.67
Family Planning	\$0.01	\$0.00	\$0.00	\$0.00	\$0.01
Hysterectomy	\$0.02	\$0.00	\$0.00	\$0.00	\$0.02
Maternity	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Sterilization	\$0.57	\$0.02	\$0.00	\$0.01	\$0.54
<b>Subtotal</b>	<b>\$46.30</b>	<b>\$2.56</b>	<b>\$0.08</b>	<b>\$2.77</b>	<b>\$40.90</b>
<b>Prescription Drugs</b>					
Basic	\$77.75	\$9.20	\$0.01	\$7.28	\$61.27
Family Planning	\$0.69	\$0.00	\$0.00	\$0.07	\$0.62
<b>Subtotal</b>	<b>\$78.45</b>	<b>\$9.20</b>	<b>\$0.01</b>	<b>\$7.35</b>	<b>\$61.89</b>
<b>Inpatient</b>					
Basic	\$72.96	\$2.32	\$0.00	\$0.00	\$70.64
Family Planning	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Hysterectomy	\$2.06	\$0.08	\$0.00	\$0.00	\$1.98
Maternity	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Newborn	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Sterilization	\$0.06	\$0.00	\$0.00	\$0.00	\$0.06
<b>Subtotal</b>	<b>\$75.08</b>	<b>\$2.40</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$72.68</b>
<b>Miscellaneous</b>					
Chemical Dependency	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
DME/Supplies	\$2.55	\$0.00	\$1.92	\$0.03	\$0.60
Exceptional Needs Care Coordinatio	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Home Health/PDN/Hospice	\$5.05	\$0.01	\$0.02	\$0.00	\$5.02
Transportation - Ambulance	\$4.42	\$0.36	\$0.05	\$0.00	\$4.01
Vision	\$5.25	\$0.10	\$4.03	\$0.14	\$0.99
<b>Subtotal</b>	<b>\$17.27</b>	<b>\$0.48</b>	<b>\$6.01</b>	<b>\$0.17</b>	<b>\$10.62</b>
<b>Total Basic Services</b>	<b>\$299.88</b>	<b>\$17.89</b>	<b>\$6.20</b>	<b>\$12.42</b>	<b>\$263.37</b>
<b>Optional Services</b>					
Maternity Management	\$0.04	\$0.00	\$0.00	\$0.04	\$0.00
<b>Total Services</b>	<b>\$299.92</b>	<b>\$17.89</b>	<b>\$6.20</b>	<b>\$12.46</b>	<b>\$263.37</b>
<b>Administration (8% on Net Cost + Copay Value)</b>					<b>\$24.46</b>
<b>Total Services with Admin</b>					<b>\$287.82</b>

Exhibits 2004  
OHPAC  
10/1/2003

**Oregon Health Plan Medicaid Demonstration**  
**Statewide Capitation Rates for October 2003 through September 2004**  
**With Adjustments for Funding Through Line 549 of the Prioritized List**

**Exhibit 2e**

Region: <b>Statewide</b>
Rate Group: <b>AB/AD with Medicare</b>

**Physician**

Basic	\$21.19
Family Planning	\$0.10
Hysterectomy	\$0.00
Maternity	\$0.00
Newborn	\$0.00
Sterilization	\$0.03
<b>Subtotal</b>	<b>\$21.34</b>

**Outpatient**

Basic	\$12.32
Emergency Room	\$2.65
Family Planning	\$0.00
Hysterectomy	\$0.00
Maternity	\$0.00
Sterilization	\$0.05
<b>Subtotal</b>	<b>\$15.02</b>

**Prescription Drugs**

Basic	\$228.54
Family Planning	\$0.85
<b>Subtotal</b>	<b>\$229.38</b>

**Inpatient**

Basic	\$6.13
Family Planning	\$0.00
Hysterectomy	\$0.02
Maternity	\$0.00
Newborn	\$0.00
Sterilization	\$0.00
<b>Subtotal</b>	<b>\$6.15</b>

**Miscellaneous**

Chemical Dependency	\$4.67
DME/Supplies	\$12.23
Exceptional Needs Care Coordinator	\$8.01
Home Health/PDN/Hospice	\$1.41
Transportation - Ambulance	\$4.01
Vision	\$2.78
<b>Subtotal</b>	<b>\$33.11</b>

<b>Total Basic Services</b>	<b>\$305.00</b>
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**Optional Services**

Maternity Management	\$0.08
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<b>Total Services</b>	<b>\$305.08</b>
<b>Total Services with 8% Admin</b>	<b>\$331.61</b>

**Mental Health**

Acute Inpatient	\$3.13
Assess & Eval	\$1.90
Case Management	\$8.54
Consultation	\$0.72
Ancillary Services	\$0.02
Med Management	\$6.37
Alternative to IP	\$3.88
Family Support	\$0.12
OP Therapy	\$10.98
Other OP	\$0.14
PEO	\$0.57
Phys IP	\$0.24
Phys OP	\$0.53
Support Day Program	\$27.64

<b>Total MH Services</b>	<b>\$64.78</b>
<b>Total MH Services with 8% Admin</b>	<b>\$70.42</b>

<b>Dental</b>	<b>\$23.42</b>
<b>Dental Services with 8% Admin</b>	<b>\$25.46</b>

**Oregon Health Plan Medicaid Demonstration  
 Statewide Capitation Rates for October 2003 through September 2004  
 With Adjustments for Funding Through Line 549 of the Prioritized List**

**Exhibit 2e**

Region: <b>Statewide</b>
Rate Group: <b>AB/AD without Medicare</b>

**Physician**

Basic	\$112.28
Family Planning	\$0.19
Hysterectomy	\$0.35
Maternity	\$0.00
Newborn	\$0.36
Sterilization	\$0.09
<b>Subtotal</b>	<b>\$113.26</b>

**Outpatient**

Basic	\$55.24
Emergency Room	\$9.22
Family Planning	\$0.02
Hysterectomy	\$0.00
Maternity	\$0.00
Sterilization	\$0.57
<b>Subtotal</b>	<b>\$65.05</b>

**Prescription Drugs**

Basic	\$180.46
Family Planning	\$0.62
<b>Subtotal</b>	<b>\$181.07</b>

**Inpatient**

Basic	\$144.42
Family Planning	\$0.00
Hysterectomy	\$1.36
Maternity	\$0.00
Newborn	\$0.91
Sterilization	\$0.16
<b>Subtotal</b>	<b>\$146.85</b>

**Miscellaneous**

Chemical Dependency	\$10.53
DME/Supplies	\$21.62
Exceptional Needs Care Coordinator	\$8.01
Home Health/PDN/Hospice	\$10.37
Transportation - Ambulance	\$10.55
Vision	\$4.16
<b>Subtotal</b>	<b>\$65.24</b>

<b>Total Basic Services</b>	<b>\$571.47</b>
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**Optional Services**

Maternity Management	\$0.15
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<b>Total Services</b>	<b>\$571.63</b>
<b>Total Services with 8% Admin</b>	<b>\$621.33</b>

**Mental Health**

Acute Inpatient	\$31.34
Assess & Eval	\$3.53
Case Management	\$9.40
Consultation	\$1.01
Ancillary Services	\$0.09
Med Management	\$8.24
Alternative to IP	\$4.59
Family Support	\$0.89
OP Therapy	\$17.86
Other OP	\$0.22
PEO	\$0.57
Phys IP	\$0.95
Phys OP	\$2.10
Support Day Program	\$24.78

<b>Total MH Services</b>	<b>\$105.58</b>
<b>Total MH Services with 8% Admin</b>	<b>\$114.77</b>

<b>Dental</b>	<b>\$21.68</b>
<b>Dental Services with 8% Admin</b>	<b>\$23.56</b>

**Oregon Health Plan Medicaid Demonstration**  
**Statewide Capitation Rates for October 2003 through September 2004**  
**With Adjustments for Funding Through Line 549 of the Prioritized List**

**Exhibit 2e**

Region: <b>Statewide</b>
Rate Group: <b>OAA with Medicare</b>

**Physician**

Basic	\$21.91
Family Planning	\$0.00
Hysterectomy	\$0.00
Maternity	\$0.00
Newborn	\$0.00
Sterilization	\$0.00
<b>Subtotal</b>	<b>\$21.92</b>

**Outpatient**

Basic	\$10.99
Emergency Room	\$1.96
Family Planning	\$0.00
Hysterectomy	\$0.00
Maternity	\$0.00
Sterilization	\$0.00
<b>Subtotal</b>	<b>\$12.95</b>

**Prescription Drugs**

Basic	\$170.22
Family Planning	\$0.04
<b>Subtotal</b>	<b>\$170.26</b>

**Inpatient**

Basic	\$8.79
Family Planning	\$0.00
Hysterectomy	\$0.02
Maternity	\$0.00
Newborn	\$0.00
Sterilization	\$0.00
<b>Subtotal</b>	<b>\$8.81</b>

**Miscellaneous**

Chemical Dependency	\$0.15
DME/Supplies	\$12.27
Exceptional Needs Care Coordinator	\$6.26
Home Health/PDN/Hospice	\$1.82
Transportation - Ambulance	\$5.89
Vision	\$3.33
<b>Subtotal</b>	<b>\$29.72</b>

<b>Total Basic Services</b>	<b>\$243.64</b>
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**Optional Services**

Maternity Management	\$0.00
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<b>Total Services</b>	<b>\$243.64</b>
<b>Total Services with 8% Admin</b>	<b>\$264.83</b>

**Mental Health**

Acute Inpatient	\$0.54
Assess & Eval	\$0.35
Case Management	\$0.92
Consultation	\$0.20
Ancillary Services	\$0.01
Med Management	\$0.67
Alternative to IP	\$0.11
Family Support	\$0.01
OP Therapy	\$1.16
Other OP	\$0.03
PEO	\$0.57
Phys IP	\$0.04
Phys OP	\$0.07
Support Day Program	\$3.43

<b>Total MH Services</b>	<b>\$8.12</b>
<b>Total MH Services with 8% Admin</b>	<b>\$8.82</b>

<b>Dental</b>	<b>\$15.01</b>
<b>Dental Services with 8% Admin</b>	<b>\$16.32</b>

**Oregon Health Plan Medicaid Demonstration**  
**Statewide Capitation Rates for October 2003 through September 2004**  
**With Adjustments for Funding Through Line 549 of the Prioritized List**

**Exhibit 2e**

Region: <b>Statewide</b>
Rate Group: <b>OAA without Medicare</b>

**Physician**

Basic	\$114.71
Family Planning	\$0.00
Hysterectomy	\$0.10
Maternity	\$0.00
Newborn	\$0.05
Sterilization	\$0.00
<b>Subtotal</b>	<b>\$114.86</b>

**Outpatient**

Basic	\$69.81
Emergency Room	\$5.11
Family Planning	\$0.00
Hysterectomy	\$0.00
Maternity	\$0.00
Sterilization	\$0.00
<b>Subtotal</b>	<b>\$74.92</b>

**Prescription Drugs**

Basic	\$103.29
Family Planning	\$0.06
<b>Subtotal</b>	<b>\$103.35</b>

**Inpatient**

Basic	\$159.15
Family Planning	\$0.00
Hysterectomy	\$0.67
Maternity	\$0.00
Newborn	\$0.00
Sterilization	\$0.00
<b>Subtotal</b>	<b>\$159.81</b>

**Miscellaneous**

Chemical Dependency	\$0.03
DME/Supplies	\$18.97
Exceptional Needs Care Coordinator	\$6.26
Home Health/PDN/Hospice	\$12.10
Transportation - Ambulance	\$15.28
Vision	\$5.40
<b>Subtotal</b>	<b>\$58.04</b>

<b>Total Basic Services</b>	<b>\$510.99</b>
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**Optional Services**

Maternity Management	\$0.00
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<b>Total Services</b>	<b>\$510.99</b>
<b>Total Services with 8% Admin</b>	<b>\$555.42</b>

**Mental Health**

Acute Inpatient	\$0.58
Assess & Eval	\$0.49
Case Management	\$0.52
Consultation	\$0.11
Ancillary Services	\$0.10
Med Management	\$1.00
Alternative to IP	\$0.00
Family Support	\$0.00
OP Therapy	\$0.68
Other OP	\$0.00
PEO	\$0.57
Phys IP	\$0.00
Phys OP	\$0.40
Support Day Program	\$3.07

<b>Total MH Services</b>	<b>\$7.51</b>
<b>Total MH Services with 8% Admin</b>	<b>\$8.17</b>

<b>Dental</b>	<b>\$25.07</b>
<b>Dental Services with 8% Admin</b>	<b>\$27.25</b>

**Oregon Health Plan Medicaid Demonstration**  
**Statewide Capitation Rates for October 2003 through September 2004**  
**With Adjustments for Funding Through Line 549 of the Prioritized List**

**Exhibit 2e**

Region: <b>Statewide</b>
Rate Group: <b>SCF Children</b>

**Physician**

Basic	\$35.02
Family Planning	\$0.10
Hysterectomy	\$0.00
Maternity	\$0.00
Newborn	\$1.17
Sterilization	\$0.00
<b>Subtotal</b>	<b>\$36.29</b>

**Outpatient**

Basic	\$9.95
Emergency Room	\$2.04
Family Planning	\$0.02
Hysterectomy	\$0.00
Maternity	\$0.00
Sterilization	\$0.11
<b>Subtotal</b>	<b>\$12.12</b>

**Prescription Drugs**

Basic	\$25.88
Family Planning	\$0.45
<b>Subtotal</b>	<b>\$26.32</b>

**Inpatient**

Basic	\$7.83
Family Planning	\$0.00
Hysterectomy	\$0.00
Maternity	\$0.00
Newborn	\$1.94
Sterilization	\$0.00
<b>Subtotal</b>	<b>\$9.77</b>

**Miscellaneous**

Chemical Dependency	\$4.39
DME/Supplies	\$1.50
Exceptional Needs Care Coordinator	\$0.00
Home Health/PDN/Hospice	\$1.15
Transportation - Ambulance	\$1.07
Vision	\$2.74
<b>Subtotal</b>	<b>\$10.85</b>

<b>Total Basic Services</b>	<b>\$95.36</b>
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**Optional Services**

Maternity Management	\$0.03
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<b>Total Services</b>	<b>\$95.39</b>
<b>Total Services with 8% Admin</b>	<b>\$103.69</b>

**Mental Health**

Acute Inpatient	\$14.55
Assess & Eval	\$6.10
Case Management	\$6.68
Consultation	\$3.62
Ancillary Services	\$0.04
Med Management	\$4.20
Alternative to IP	\$6.23
Family Support	\$2.72
OP Therapy	\$46.88
Other OP	\$0.55
PEO	\$0.57
Phys IP	\$0.59
Phys OP	\$2.30
Support Day Program	\$12.74

<b>Total MH Services</b>	<b>\$107.76</b>
<b>Total MH Services with 8% Admin</b>	<b>\$117.13</b>

<b>Dental</b>	<b>\$17.16</b>
<b>Dental Services with 8% Admin</b>	<b>\$18.65</b>

**Oregon Health Plan Medicaid Demonstration  
 FY 2004 Capitation Rates  
 Adjustments Applied to Statewide Capitation Rates**

**Exhibit 2f**

Category of Service	TANF Adults	PLM Adults	PLM, CHIP, and TANF Children Aged 0-1	PLM, CHIP, and TANF Children Aged 1-5	PLM, CHIP, and TANF Children Aged 6-18	AB/AD without Medicare
<b>Physician</b>						
Basic	CDPS	none	Newborn	CDPS	CDPS	CDPS
Family Planning	CDPS	none	Newborn	CDPS	CDPS	CDPS
Hysterectomy	CDPS	none	Newborn	CDPS	CDPS	CDPS
Maternity	N/A	N/A	N/A	N/A	N/A	N/A
Newborn	CDPS	none	Newborn	CDPS	CDPS	CDPS
Sterilization	CDPS	none	Newborn	CDPS	CDPS	CDPS
<b>Outpatient</b>						
Basic	CDPS, OP Geo	OP Geo	Newborn, OP Geo	CDPS, OP Geo	CDPS, OP Geo	CDPS, OP Geo
Emergency Room	CDPS, OP Geo	OP Geo	Newborn, OP Geo	CDPS, OP Geo	CDPS, OP Geo	CDPS, OP Geo
Family Planning	CDPS, OP Geo	OP Geo	Newborn, OP Geo	CDPS, OP Geo	CDPS, OP Geo	CDPS, OP Geo
Hysterectomy	CDPS, OP Geo	OP Geo	Newborn, OP Geo	CDPS, OP Geo	CDPS, OP Geo	CDPS, OP Geo
Maternity	N/A	N/A	N/A	N/A	N/A	N/A
Sterilization	CDPS, OP Geo	OP Geo	Newborn, OP Geo	CDPS, OP Geo	CDPS, OP Geo	CDPS, OP Geo
<b>Prescription Drugs</b>						
Basic	CDPS	none	Newborn	CDPS	CDPS	CDPS
Family Planning	CDPS	none	Newborn	CDPS	CDPS	CDPS
<b>Inpatient</b>						
Basic	CDPS, IP Geo	IP Geo	Newborn, IP Geo	CDPS, IP Geo	CDPS, IP Geo	CDPS, IP Geo
Family Planning	CDPS, IP Geo	IP Geo	Newborn, IP Geo	CDPS, IP Geo	CDPS, IP Geo	CDPS, IP Geo
Hysterectomy	CDPS, IP Geo	IP Geo	Newborn, IP Geo	CDPS, IP Geo	CDPS, IP Geo	CDPS, IP Geo
Maternity	N/A	N/A	N/A	N/A	N/A	N/A
Newborn	CDPS, IP Geo	IP Geo	Newborn, IP Geo	CDPS, IP Geo	CDPS, IP Geo	CDPS, IP Geo
Sterilization	CDPS, IP Geo	IP Geo	Newborn, IP Geo	CDPS, IP Geo	CDPS, IP Geo	CDPS, IP Geo
<b>Miscellaneous</b>						
Chemical Dependency	Methadone	none	none	none	none	Methadone
DME/Supplies	CDPS	none	Newborn	CDPS	CDPS	CDPS
Exceptional Needs Care Coordination	CDPS	none	Newborn	CDPS	CDPS	CDPS
Home Health/PDN/Hospice	CDPS	none	Newborn	CDPS	CDPS	CDPS
Transportation - Ambulance	CDPS	none	Newborn	CDPS	CDPS	CDPS
Vision	CDPS	none	Newborn	CDPS	CDPS	CDPS
<b>Optional Services</b>						
Maternity Management	CDPS	none	Newborn	CDPS	CDPS	CDPS
<b>Mental Health</b>						
Acute Inpatient	MH Geo	MH Geo	MH Geo	MH Geo	MH Geo	MH Geo
Assess & Eval	none	none	none	none	none	none
Case Management	none	none	none	none	none	none
Consultation	none	none	none	none	none	none
Ancillary Services	none	none	none	none	none	none
Med Management	none	none	none	none	none	none
Alternative to IP	none	none	none	none	none	none
Family Support	none	none	none	none	none	none
OP Therapy	none	none	none	none	none	none
Other OP	none	none	none	none	none	none
PEO	none	none	none	none	none	none
Phys IP	none	none	none	none	none	none
Phys OP	none	none	none	none	none	none
Support Day Program	none	none	none	none	none	none
<b>Dental</b>	Dental	Dental	Dental	Dental	Dental	Dental

**Oregon Health Plan Medicaid Demonstration  
 FY 2004 Capitation Rates  
 Adjustments Applied to Statewide Capitation Rates**

**Exhibit 2f**

Category of Service	AB/AD with Medicare	OAA without Medicare	OAA with Medicare	SCF Children	OHP Families	OHP Adults and Couples
<b>Physician</b>						
Basic	CDPS	none	none	none	CDPS	CDPS
Family Planning	CDPS	none	none	none	CDPS	CDPS
Hysterectomy	CDPS	none	none	none	CDPS	CDPS
Maternity	N/A	N/A	N/A	N/A	N/A	N/A
Newborn	CDPS	none	none	none	CDPS	CDPS
Sterilization	CDPS	none	none	none	CDPS	CDPS
<b>Outpatient</b>						
Basic	CDPS, OP Geo	OP Geo	OP Geo	OP Geo	CDPS, OP Geo	CDPS, OP Geo
Emergency Room	CDPS, OP Geo	OP Geo	OP Geo	OP Geo	CDPS, OP Geo	CDPS, OP Geo
Family Planning	CDPS, OP Geo	OP Geo	OP Geo	OP Geo	CDPS, OP Geo	CDPS, OP Geo
Hysterectomy	CDPS, OP Geo	OP Geo	OP Geo	OP Geo	CDPS, OP Geo	CDPS, OP Geo
Maternity	N/A	N/A	N/A	N/A	N/A	N/A
Sterilization	CDPS, OP Geo	OP Geo	OP Geo	OP Geo	CDPS, OP Geo	CDPS, OP Geo
<b>Prescription Drugs</b>						
Basic	CDPS	none	none	none	CDPS	CDPS
Family Planning	CDPS	none	none	none	CDPS	CDPS
<b>Inpatient</b>						
Basic	CDPS, IP Geo	IP Geo	IP Geo	IP Geo	CDPS, IP Geo	CDPS, IP Geo
Family Planning	CDPS, IP Geo	IP Geo	IP Geo	IP Geo	CDPS, IP Geo	CDPS, IP Geo
Hysterectomy	CDPS, IP Geo	IP Geo	IP Geo	IP Geo	CDPS, IP Geo	CDPS, IP Geo
Maternity	N/A	N/A	N/A	N/A	N/A	N/A
Newborn	CDPS, IP Geo	IP Geo	IP Geo	IP Geo	CDPS, IP Geo	CDPS, IP Geo
Sterilization	CDPS, IP Geo	IP Geo	IP Geo	IP Geo	CDPS, IP Geo	CDPS, IP Geo
<b>Miscellaneous</b>						
Chemical Dependency	Methadone	none	none	none	N/A	N/A
DME/Supplies	CDPS	none	none	none	CDPS	CDPS
Exceptional Needs Care Coordination	CDPS	none	none	none	CDPS	CDPS
Home Health/PDN/Hospice	CDPS	none	none	none	CDPS	CDPS
Transportation - Ambulance	CDPS	none	none	none	CDPS	CDPS
Vision	CDPS	none	none	none	CDPS	CDPS
<b>Optional Services</b>						
Maternity Management	CDPS	none	none	none	CDPS	CDPS
<b>Mental Health</b>						
Acute Inpatient	MH Geo	MH Geo	MH Geo	ResMed, MH Geo	N/A	N/A
Assess & Eval	none	none	none	ResMed	N/A	N/A
Case Management	none	none	none	ResMed	N/A	N/A
Consultation	none	none	none	ResMed	N/A	N/A
Ancillary Services	none	none	none	ResMed	N/A	N/A
Med Management	none	none	none	ResMed	N/A	N/A
Alternative to IP	none	none	none	ResMed	N/A	N/A
Family Support	none	none	none	ResMed	N/A	N/A
OP Therapy	none	none	none	ResMed	N/A	N/A
Other OP	none	none	none	ResMed	N/A	N/A
PEO	none	none	none	ResMed	N/A	N/A
Phys IP	none	none	none	ResMed	N/A	N/A
Phys OP	none	none	none	ResMed	N/A	N/A
Support Day Program	none	none	none	ResMed	N/A	N/A
<b>Dental</b>	Dental	Dental	Dental	Dental	N/A	N/A

**Oregon Health Plan Medicaid Demonstration**  
**FY2004 Capitation Rates**  
**FCHP Geographic Factors**

**Exhibit 3a**

Plan Name	Region	Inpatient	Outpatient
CareOregon, Inc.	Jackson/Josephine/Douglas	0.9474	0.9986
CareOregon, Inc.	Linn/Benton/Marion/Polk/Yamhill	1.0125	1.0137
CareOregon, Inc.	Other	1.0821	1.0717
CareOregon, Inc.	Tri-County (Clackamas, Multnomah, Washington)	0.9434	0.9726
Cascade Comprehensive Care, Inc.	Other	1.1039	0.9464
Central Oregon Independent Health Services, Inc.	Other	1.1432	1.0461
Douglas County Individual Practice Association	Jackson/Josephine/Douglas	1.0234	0.9939
Doctors of the Oregon Coast South	Other	1.0742	1.1120
FamilyCare, Inc.	Jackson/Josephine/Douglas	0.9532	0.9589
FamilyCare, Inc.	Other	1.1781	1.1580
FamilyCare, Inc.	Tri-County (Clackamas, Multnomah, Washington)	0.9431	0.9727
InterCommunity Health Plans, Inc.	Linn/Benton/Marion/Polk/Yamhill	1.1105	0.9993
Lane Individual Practice Association, Inc.	Lane	0.9679	0.9888
Marion-Polk Community Health Plan	Linn/Benton/Marion/Polk/Yamhill	0.9818	1.0152
Mid-Rogue Independent Practice Association	Jackson/Josephine/Douglas	0.9551	0.9551
Grants Pass Management Services, Inc. abn Oregon Health Management Services	Jackson/Josephine/Douglas	0.9561	0.9563
Providence Health Plan, Inc.	Linn/Benton/Marion/Polk/Yamhill	1.1949	1.0080
Providence Health Plan, Inc.	Tri-County (Clackamas, Multnomah, Washington)	0.9429	0.9724
Tuality Health Alliance	Tri-County (Clackamas, Multnomah, Washington)	0.9474	0.9737

**Oregon Health Plan Medicaid Demonstration  
FY2004 Capitation Rates  
CDPS Risk Adjustment Factors**

**Exhibit 3b**

Plan Name	TANF Adults	AB/AD without Medicare	AB/AD with Medicare	PLM, CHIP, or TANF Children Aged 1-5	PLM, CHIP, or TANF Children Aged 6-18	OHP Adults and Couples	OHP Families
CareOregon, Inc.	0.9775	1.0222	1.0193	1.0012	0.9778	n/a	n/a
Cascade Comprehensive Care, Inc.	1.1143	1.1123	1.1092	0.9580	1.0651	1.1117	1.1874
Central Oregon Independent Health Services, Inc.	1.0007	1.0896	1.0865	1.0949	1.0326	n/a	n/a
Douglas County Individual Practice Association, Inc.	1.1539	1.1306	1.1274	1.0854	1.1382	n/a	n/a
Doctors of the Coast South abn South West Oregon Individual Practice Association, Inc.	1.0383	0.9510	0.9483	1.0937	1.1071	0.9325	1.1022
FamilyCare Health Plans, Inc.	0.8526	0.8500	0.8500	0.8500	0.8743	0.8500	0.8500
InterCommunity Health Plans, Inc. abn Intercommunity Health Network	1.0857	0.9841	0.9813	1.0348	1.0526	0.9522	0.9942
Lane Individual Practice Association, Inc.	0.9412	0.8543	0.8519	0.9533	0.9859	0.9014	0.9550
Marion/Polk Community Health Plan, LLC	1.0394	0.9936	0.9908	0.9940	1.0099	0.9714	1.0057
Mid-Rogue Independent Practice Association, Inc. abn Mid-Rogue IPA	1.0134	0.9802	0.9774	0.9235	0.9113	0.9771	1.0056
Grants Pass Management Services, Inc. abn Oregon Health Management Services	1.0789	0.9099	0.9074	0.9609	1.0661	0.9283	1.0144
Providence Health Plan, Inc.	0.8651	1.1188	1.1157	1.0039	0.8767	1.2771	0.9001
Tuality Health Alliance	0.9815	0.9640	0.9613	0.9882	0.9904	n/a	n/a

Note: Plans with "n/a" CDPS risk adjustment factors for the OHPAC and OHPFAM populations have elected not to contract for OHP Standard.

**Oregon Health Plan Medicaid Demonstration  
 FY2004 Capitation Rates  
 Chemical Dependency Risk Adjustment Factors**

**Exhibit 3c**

Plan Name	Region	AB/AD with Medicare	AB/AD without Medicare	TANF
CareOregon, Inc.	Jackson/Josephine/Douglas	0.7032	0.8512	1.2198
CareOregon, Inc.	Linn/Benton/Marion/Polk/Yamhill	1.1610	1.7208	1.0397
CareOregon, Inc.	Other	0.8204	0.6487	0.7852
CareOregon, Inc.	Tri-County (Clackamas, Multnomah, Washington)	1.7835	1.6586	1.2674
Cascade Comprehensive Care, Inc.	Other	0.7646	0.5573	0.8646
Central Oregon Independent Health Services, Inc.	Other	0.8387	0.5461	0.7769
Douglas County Individual Practice Association	Jackson/Josephine/Douglas	0.7771	0.5663	0.8961
Deschutes County Human Svcs	Other	0.7491	0.5676	0.7769
Doctors of the Oregon Coast South	Other	0.6546	0.5092	0.8612
FamilyCare, Inc.	Jackson/Josephine/Douglas	0.5858	0.7287	0.8056
FamilyCare, Inc.	Other	0.5858	0.4283	0.6626
FamilyCare, Inc.	Tri-County (Clackamas, Multnomah, Washington)	0.6310	0.6195	0.8232
InterCommunity Health Plans, Inc.	Linn/Benton/Marion/Polk/Yamhill	0.7176	0.9311	1.0701
Lane Individual Practice Association, Inc.	Lane	0.8124	0.8666	1.0031
Marion-Polk Community Health Plan	Linn/Benton/Marion/Polk/Yamhill	0.8167	0.7004	0.9628
Mid-Rogue Independent Practice Association	Jackson/Josephine/Douglas	0.6746	0.8648	0.8557
Oregon Health Management Services	Jackson/Josephine/Douglas	0.8207	1.4481	0.9669
Providence Health Plan, Inc.	Linn/Benton/Marion/Polk/Yamhill	0.7691	0.5605	0.6722
Providence Health Plan, Inc.	Tri-County (Clackamas, Multnomah, Washington)	0.7691	0.7573	0.7255
Tuality Health Alliance	Tri-County (Clackamas, Multnomah, Washington)	0.6635	0.4844	0.7722

**Oregon Health Plan Medicaid Demonstration  
 FY2004 Capitation Rates  
 Newborn Adjustment Factors**

**Exhibit 3d**

Plan Name	Adjustment
CareOregon, Inc.	0.9582
Cascade Comprehensive Care, Inc.	1.2062
Central Oregon Independent Health Services, Inc.	1.0468
Douglas County Individual Practice Association, Inc.	1.0088
Doctors of the Coast South abn South West Oregon Individual Practice Association, Inc.	1.1128
FamilyCare Health Plans, Inc.	1.1279
InterCommunity Health Plans, Inc. abn Intercommunity Health Network	1.0648
Lane Individual Practice Association, Inc.	0.9769
Marion/Polk Community Health Plan, LLC	0.9847
Mid-Rogue Independent Practice Association, Inc. abn Mid-Rogue IPA	1.2617
Grants Pass Management Services, Inc. abn Oregon Health Management Services	1.1632
Providence Health Plan, Inc.	0.9520
Tuality Health Alliance	0.9904

**Oregon Health Plan Medicaid Demonstration  
Comparison of FY 2004 and FY 2003 Physical Health Capitation Rates  
Including Administration**

**Exhibit 3e**

<b>Statewide FCHP Rates</b>			
<b>Eligibility Category</b>	<b>FY 2004</b>	<b>FY 2003</b>	<b>% Change</b>
TANF	\$254.01	\$142.56	78.2%
General Assistance	N/A	\$707.50	N/A
PLM Adults	\$237.68	\$679.88	-65.0%
PLM, CHIP or TANF Children Aged 0-1	\$349.62	\$284.31	23.0%
PLM, CHIP or TANF Children Aged 1-5	\$69.18	\$56.47	22.5%
PLM, CHIP or TANF Children Aged 6-18	\$59.36	\$55.48	7.0%
OHP Families	\$159.65	\$165.32	-3.4%
OHP Adults and Couples	\$287.82	\$281.74	2.2%
AB/AD with Medicare	\$331.61	\$358.95	-7.6%
AB/AD without Medicare	\$621.33	\$528.26	17.6%
OAA with Medicare	\$264.83	\$335.73	-21.1%
OAA without Medicare	\$555.42	\$609.01	-8.8%
SCF Children	\$103.69	\$108.52	-4.5%
Weighted Average - June 2003 population	\$201.09	\$205.10	-2.0%

Notes:

**The composition of several eligibility categories changed for FY 03/04. Specifically, TANF reflects adults only, and the TANF children have been moved with the PLM and CHIP children. General Assistance has been eliminated.**

**The FY 2004 capitation rates exclude maternity-related services as maternity will be paid on a case rate basis.**

**Oregon Health Plan Medicaid Demonstration**  
**Comparison of FY 2004 and FY 2003 Physical Health Rates**  
**Including Administration**

**Exhibit 3e**

CareOregon, Inc.															
Eligibility Category	JJD			Lane			LBMPY			Other			Tri-Counties		
	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change
TANF	\$247.37	\$142.08	74.1%				\$248.11	\$141.29	75.6%	\$249.88	\$139.17	79.5%	\$246.73	\$142.68	72.9%
General Assistance	N/A	\$704.50	N/A				N/A	\$756.79	N/A	N/A	\$714.51	N/A	N/A	\$747.86	N/A
PLM Adults	\$220.62	\$651.13	-66.1%				\$223.34	\$659.44	-66.1%	\$228.55	\$660.13	-65.4%	\$219.08	\$661.96	-66.9%
PLM, CHIP or TANF Children Aged 0-1	\$325.68	\$275.74	18.1%				\$337.53	\$280.56	20.3%	\$351.17	\$281.83	24.6%	\$324.38	\$281.41	15.3%
PLM, CHIP or TANF Children Aged 1-5	\$68.76	\$56.04	22.7%				\$69.58	\$56.28	23.6%	\$71.04	\$55.92	27.0%	\$68.35	\$56.61	20.8%
PLM, CHIP or TANF Children Aged 6-18	\$57.46	\$54.86	4.7%				\$58.11	\$55.14	5.4%	\$59.22	\$54.88	7.9%	\$57.17	\$55.43	3.1%
OHP Families	N/A	\$163.22	N/A				N/A	\$165.03	N/A	N/A	\$162.13	N/A	N/A	\$168.98	N/A
OHP Adults and Couples	N/A	\$299.13	N/A				N/A	\$306.74	N/A	N/A	\$295.92	N/A	N/A	\$317.80	N/A
AB/AD with Medicare	\$335.94	\$356.84	-5.9%				\$338.96	\$362.56	-6.5%	\$338.67	\$355.47	-4.7%	\$340.96	\$362.72	-6.0%
AB/AD without Medicare	\$624.31	\$540.52	15.5%				\$645.99	\$550.03	17.4%	\$649.25	\$539.44	20.4%	\$631.04	\$550.81	14.6%
OAA with Medicare	\$264.31	\$334.87	-21.1%				\$265.14	\$335.32	-20.9%	\$266.62	\$333.84	-20.1%	\$263.90	\$336.50	-21.6%
OAA without Medicare	\$546.17	\$602.95	-9.4%				\$558.70	\$606.31	-7.9%	\$575.52	\$602.69	-4.5%	\$543.36	\$610.03	-10.9%
SCF Children	\$103.08	\$107.59	-4.2%				\$103.97	\$108.07	-3.8%	\$105.47	\$107.66	-2.0%	\$102.69	\$108.53	-5.4%
Weighted Average	\$157.89	\$168.64	-6.4%				\$148.40	\$157.50	-5.8%	\$202.33	\$201.94	0.2%	\$195.31	\$203.12	-3.8%

**Notes:**

The composition of several eligibility categories changed for FY 03/04. Specifically, TANF reflects adults only, and the TANF children have been moved with the PLM and CHIP children. General Assistance has been eliminated.

The FY 2004 capitation rates exclude maternity-related services as maternity will be paid on a case rate basis.

**Oregon Health Plan Medicaid Demonstration**  
**Comparison of FY 2004 and FY 2003 Physical Health Capitation Rates**  
**Including Administration**

**Exhibit 3e**

Cascade Comprehensive Care, Inc.															
Eligibility Category	JJD			Lane			LBMPY			Other			Tri-Counties		
	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change
TANF										\$281.55	\$158.34	77.8%			
General Assistance										N/A	\$843.45	N/A			
PLM Adults										\$237.77	\$737.57	-67.8%			
PLM, CHIP or TANF Children Aged 0-1										\$443.27	\$318.96	39.0%			
PLM, CHIP or TANF Children Aged 1-5										\$66.47	\$57.51	15.6%			
PLM, CHIP or TANF Children Aged 6-18										\$63.50	\$56.90	11.6%			
OHP Families										\$191.51	\$169.24	13.2%			
OHP Adults and Couples										\$326.46	\$329.18	-0.8%			
AB/AD with Medicare										\$365.87	\$357.39	2.4%			
AB/AD without Medicare										\$699.00	\$631.54	10.7%			
OAA with Medicare										\$265.07	\$336.41	-21.2%			
OAA without Medicare										\$569.11	\$626.12	-9.1%			
SCF Children										\$104.08	\$111.06	-6.3%			
Weighted Average										\$233.12	\$236.95	-1.6%			

**Notes:**

The composition of several eligibility categories changed for FY 03/04. Specifically, TANF reflects adults only, and the TANF children have been moved with the PLM and CHIP children. General Assistance has been eliminated.

The FY 2004 capitation rates exclude maternity-related services as maternity will be paid on a case rate basis.

**Oregon Health Plan Medicaid Demonstration**  
**Comparison of FY 2004 and FY 2003 Physical Health Capitation Rates**  
**Including Administration**

**Exhibit 3e**

Central Oregon Independent Health Services, Inc.															
Eligibility Category	JJD			Lane			LBMPY			Other			Tri-Counties		
	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change
TANF										\$256.86	\$140.25	83.1%			
General Assistance										N/A	\$771.70	N/A			
PLM Adults										\$228.93	\$668.32	-65.7%			
PLM, CHIP or TANF Children Aged 0-1										\$394.79	\$287.43	37.4%			
PLM, CHIP or TANF Children Aged 1-5										\$77.92	\$55.80	39.6%			
PLM, CHIP or TANF Children Aged 6-18										\$62.76	\$54.89	14.3%			
OHP Families										N/A	\$161.85	N/A			
OHP Adults and Couples										N/A	\$291.84	N/A			
AB/AD with Medicare										\$360.80	\$354.19	1.9%			
AB/AD without Medicare										\$699.03	\$584.82	19.5%			
OAA with Medicare										\$266.85	\$332.82	-19.8%			
OAA without Medicare										\$584.05	\$602.23	-3.0%			
SCF Children										\$105.78	\$107.70	-1.8%			
Weighted Average										\$199.39	\$194.96	2.3%			

**Notes:**

The composition of several eligibility categories changed for FY 03/04. Specifically, TANF reflects adults only, and the TANF children have been moved with the PLM and CHIP children. General Assistance has been eliminated.

The FY 2004 capitation rates exclude maternity-related services as maternity will be paid on a case rate basis.

**Oregon Health Plan Medicaid Demonstration**  
**Comparison of FY 2004 and FY 2003 Physical Health Capitation Rates**  
**Including Administration**

Exhibit 3e

Douglas County Individual Practice Association, Inc.															
Eligibility Category	JJD			Lane			LBMPY			Other			Tri-Counties		
	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change
TANF	\$287.41	\$140.15	105.1%												
General Assistance	N/A	\$764.07	N/A												
PLM Adults	\$222.58	\$679.83	-67.3%												
PLM, CHIP or TANF Children Aged 0-1	\$356.92	\$291.67	22.4%												
PLM, CHIP or TANF Children Aged 1-5	\$75.23	\$57.16	31.6%												
PLM, CHIP or TANF Children Aged 6-18	\$67.51	\$56.08	20.4%												
OHP Families	N/A	\$165.62	N/A												
OHP Adults and Couples	N/A	\$295.73	N/A												
AB/AD with Medicare	\$372.06	\$359.68	3.4%												
AB/AD without Medicare	\$699.58	\$577.43	21.2%												
OAA with Medicare	\$264.97	\$337.66	-21.5%												
OAA without Medicare	\$558.99	\$617.78	-9.5%												
SCF Children	\$103.82	\$109.62	-5.3%												
Weighted Average	\$228.69	\$217.57	5.1%												

**Notes:**

The composition of several eligibility categories changed for FY 03/04. Specifically, TANF reflects adults only, and the TANF children have been moved with the PLM and CHIP children. General Assistance has been eliminated.

The FY 2004 capitation rates exclude maternity-related services as maternity will be paid on a case rate basis.

**Oregon Health Plan Medicaid Demonstration**  
**Comparison of FY 2004 and FY 2003 Physical Health Capitation Rates**  
**Including Administration**

**Exhibit 3e**

Southwest Oregon Independent Physician Association, Inc. abn Doctors of the Oregon Coast South															
Eligibility Category	JJD			Lane			LBMPY			Other			Tri-Counties		
	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change
TANF										\$267.41	\$146.48	82.6%			
General Assistance										N/A	\$719.87	N/A			
PLM Adults										\$230.53	\$702.51	-67.2%			
PLM, CHIP or TANF Children Aged 0-1										\$407.29	\$303.82	34.1%			
PLM, CHIP or TANF Children Aged 1-5										\$78.15	\$58.23	34.2%			
PLM, CHIP or TANF Children Aged 6-18										\$67.44	\$57.19	17.9%			
OHP Families										\$182.13	\$169.56	7.4%			
OHP Adults and Couples										\$278.53	\$284.32	-2.0%			
AB/AD with Medicare										\$315.09	\$362.83	-13.2%			
AB/AD without Medicare										\$604.43	\$540.52	11.8%			
OAA with Medicare										\$267.12	\$340.62	-21.6%			
OAA without Medicare										\$577.43	\$631.44	-8.6%			
SCF Children										\$105.92	\$111.44	-5.0%			

Weighted Average

\$241.58 \$244.64 -1.3%

**Notes:**

The composition of several eligibility categories changed for FY 03/04. Specifically, TANF reflects adults only, and the TANF children have been moved with the PLM and CHIP children. General Assistance has been eliminated.

The FY 2004 capitation rates exclude maternity-related services as maternity will be paid on a case rate basis.

**Oregon Health Plan Medicaid Demonstration**  
**Comparison of FY 2004 and FY 2003 Physical Health Capitation Rates**  
**Including Administration**

**Exhibit 3e**

FamilyCare Health Plans, Inc.															
Eligibility Category	JJD			Lane			LBMPY			Other			Tri-Counties		
	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change
TANF	\$210.52	\$150.96	39.5%							\$224.57	\$149.17	50.5%	\$210.96	\$151.98	38.8%
General Assistance	N/A	\$579.10	N/A							N/A	\$577.22	N/A	N/A	\$589.30	N/A
PLM Adults	\$218.62	\$655.88	-66.7%							\$236.07	\$653.06	-63.9%	\$219.08	\$661.99	-66.9%
PLM, CHIP or TANF Children Aged 0-1	\$383.50	\$278.84	37.5%							\$435.66	\$277.22	57.2%	\$381.77	\$281.44	35.7%
PLM, CHIP or TANF Children Aged 1-5	\$57.94	\$56.03	3.4%							\$62.11	\$55.94	11.0%	\$58.03	\$56.60	2.5%
PLM, CHIP or TANF Children Aged 6-18	\$51.06	\$54.91	-7.0%							\$54.38	\$54.80	-0.8%	\$51.12	\$55.43	-7.8%
OHP Families	\$133.43	\$162.14	-17.7%							N/A	\$161.12	N/A	N/A	\$165.03	N/A
OHP Adults and Couples	\$239.94	\$232.26	3.3%							N/A	\$229.23	N/A	N/A	\$234.84	N/A
AB/AD with Medicare	\$279.63	\$356.33	-21.5%							\$283.67	\$356.50	-20.4%	\$279.99	\$360.09	-22.2%
AB/AD without Medicare	\$517.78	\$441.67	17.2%							\$556.81	\$440.00	26.5%	\$515.99	\$449.23	14.9%
OAA with Medicare	\$263.80	\$334.51	-21.1%							\$268.76	\$334.33	-19.6%	\$263.90	\$336.48	-21.6%
OAA without Medicare	\$543.95	\$603.29	-9.8%							\$599.22	\$602.09	-0.5%	\$543.31	\$609.99	-10.9%
SCF Children	\$102.62	\$107.68	-4.7%							\$107.63	\$107.51	0.1%	\$102.69	\$108.52	-5.4%
Weighted Average	\$165.36	\$182.66	-9.5%							\$186.92	\$196.05	-4.7%	\$166.45	\$193.30	-13.9%

**Notes:**

The composition of several eligibility categories changed for FY 03/04. Specifically, TANF reflects adults only, and the TANF children have been moved with the PLM and CHIP children. General Assistance has been eliminated.

The FY 2004 capitation rates exclude maternity-related services as maternity will be paid on a case rate basis.

**Oregon Health Plan Medicaid Demonstration**  
**Comparison of FY 2004 and FY 2003 Physical Health Capitation Rates**  
**Including Administration**

Exhibit 3e

InterCommunity Health Plans, Inc. abn Intercommunity Health Network															
Eligibility Category	JJD			Lane			LBMPY			Other			Tri-Counties		
	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change
TANF							\$278.19	\$137.52	102.3%						
General Assistance							N/A	\$676.81	N/A						
PLM Adults							\$225.41	\$645.20	-65.1%						
PLM, CHIP or TANF Children Aged 0-1							\$393.94	\$273.31	44.1%						
PLM, CHIP or TANF Children Aged 1-5							\$72.64	\$55.44	31.0%						
PLM, CHIP or TANF Children Aged 6-18							\$63.20	\$54.32	16.4%						
OHP Families							\$162.09	\$159.87	1.4%						
OHP Adults and Couples							\$282.36	\$267.23	5.7%						
AB/AD with Medicare							\$324.71	\$354.51	-8.4%						
AB/AD without Medicare							\$628.00	\$515.37	21.9%						
OAA with Medicare							\$265.88	\$332.78	-20.1%						
OAA without Medicare							\$574.56	\$595.99	-3.6%						
SCF Children							\$104.82	\$106.72	-1.8%						
Weighted Average							\$220.92	\$210.05	5.2%						

**Notes:**

The composition of several eligibility categories changed for FY 03/04. Specifically, TANF reflects adults only, and the TANF children have been moved with the PLM and CHIP children. General Assistance has been eliminated.

The FY 2004 capitation rates exclude maternity-related services as maternity will be paid on a case rate basis.

**Oregon Health Plan Medicaid Demonstration**  
**Comparison of FY 2004 and FY 2003 Physical Health Capitation Rates**  
**Including Administration**

**Exhibit 3e**

Lane Individual Practice Association, Inc.															
Eligibility Category	JJD			Lane			LBMPY			Other			Tri-Counties		
	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change
TANF				\$236.02	\$145.25	62.5%									
General Assistance				N/A	\$639.61	N/A									
PLM Adults				\$220.68	\$672.11	-67.2%									
PLM, CHIP or TANF Children Aged 0-1				\$335.48	\$287.09	16.9%									
PLM, CHIP or TANF Children Aged 1-5				\$65.52	\$56.98	15.0%									
PLM, CHIP or TANF Children Aged 6-18				\$58.00	\$55.85	3.9%									
OHP Families				\$151.19	\$167.87	-9.9%									
OHP Adults and Couples				\$256.69	\$258.35	-0.6%									
AB/AD with Medicare				\$281.88	\$361.26	-22.0%									
AB/AD without Medicare				\$525.73	\$478.64	9.8%									
OAA with Medicare				\$264.36	\$337.41	-21.6%									
OAA without Medicare				\$548.93	\$615.08	-10.8%									
SCF Children				\$103.17	\$109.22	-5.5%									
Weighted Average				\$192.87	\$210.29	-8.3%									

**Notes:**

The composition of several eligibility categories changed for FY 03/04. Specifically, TANF reflects adults only, and the TANF children have been moved with the PLM and CHIP children. General Assistance has been eliminated.

The FY 2004 capitation rates exclude maternity-related services as maternity will be paid on a case rate basis.

**Oregon Health Plan Medicaid Demonstration**  
**Comparison of FY 2004 and FY 2003 Physical Health Capitation Rates**  
**Including Administration**

**Exhibit 3e**

Marion/Polk Community Health Plan, LLC															
Eligibility Category	JJD			Lane			LBMPY			Other			Tri-Counties		
	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change
TANF							\$260.38	\$142.49	82.7%						
General Assistance							N/A	\$691.04	N/A						
PLM Adults							\$222.53	\$659.31	-66.2%						
PLM, CHIP or TANF Children Aged 0-1							\$341.32	\$280.18	21.8%						
PLM, CHIP or TANF Children Aged 1-5							\$68.81	\$56.40	22.0%						
PLM, CHIP or TANF Children Aged 6-18							\$59.79	\$55.24	8.2%						
OHP Families							\$160.43	\$164.03	-2.2%						
OHP Adults and Couples							\$278.84	\$275.42	1.2%						
AB/AD with Medicare							\$327.72	\$358.19	-8.5%						
AB/AD without Medicare							\$612.01	\$526.04	16.3%						
OAA with Medicare							\$264.87	\$335.83	-21.1%						
OAA without Medicare							\$553.49	\$607.59	-8.9%						
SCF Children							\$103.66	\$108.22	-4.2%						
Weighted Average							\$195.43	\$199.98	-2.3%						

**Notes:**

The composition of several eligibility categories changed for FY 03/04. Specifically, TANF reflects adults only, and the TANF children have been moved with the PLM and CHIP children. General Assistance has been eliminated.

The FY 2004 capitation rates exclude maternity-related services as maternity will be paid on a case rate basis.

**Oregon Health Plan Medicaid Demonstration**  
**Comparison of FY 2004 and FY 2003 Physical Health Capitation Rates**  
**Including Administration**

**Exhibit 3e**

<b>Mid-Rogue Independent Practice Association, Inc. abn Mid-Rogue IPA</b>															
<b>Eligibility Category</b>	<b>JJD</b>			<b>Lane</b>			<b>LBMPY</b>			<b>Other</b>			<b>Tri-Counties</b>		
	<b>FY 2004</b>	<b>FY 2003</b>	<b>% Change</b>	<b>FY 2004</b>	<b>FY 2003</b>	<b>% Change</b>	<b>FY 2004</b>	<b>FY 2003</b>	<b>% Change</b>	<b>FY 2004</b>	<b>FY 2003</b>	<b>% Change</b>	<b>FY 2004</b>	<b>FY 2003</b>	<b>% Change</b>
TANF	\$248.61	\$138.39	79.6%												
General Assistance	N/A	\$670.53	N/A												
PLM Adults	\$218.46	\$656.57	-66.7%												
PLM, CHIP or TANF Children Aged 0-1	\$429.29	\$279.28	53.7%												
PLM, CHIP or TANF Children Aged 1-5	\$62.92	\$56.03	12.3%												
PLM, CHIP or TANF Children Aged 6-18	\$53.20	\$54.92	-3.1%												
OHP Families	\$157.80	\$161.85	-2.5%												
OHP Adults and Couples	\$275.80	\$277.76	-0.7%												
AB/AD with Medicare	\$321.49	\$356.36	-9.8%												
AB/AD without Medicare	\$597.39	\$510.36	17.1%												
OAA with Medicare	\$263.77	\$334.48	-21.1%												
OAA without Medicare	\$543.96	\$603.40	-9.9%												
SCF Children	\$102.59	\$107.70	-4.8%												
Weighted Average	\$223.27	\$228.28	-2.2%												

**Notes:**

The composition of several eligibility categories changed for FY 03/04. Specifically, TANF reflects adults only, and the TANF children have been moved with the PLM and CHIP children. General Assistance has been eliminated.

The FY 2004 capitation rates exclude maternity-related services as maternity will be paid on a case rate basis.

**Oregon Health Plan Medicaid Demonstration**  
**Comparison of FY 2004 and FY 2003 Physical Health Capitation Rates**  
**Including Administration**

Exhibit 3e

Grants Pass Management Services, Inc. abn Oregon Health Management Services															
Eligibility Category	JJD			Lane			LBMPY			Other			Tri-Counties		
	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change
TANF	\$265.62	\$136.90	94.0%												
General Assistance	N/A	\$677.03	N/A												
PLM Adults	\$218.56	\$656.64	-66.7%												
PLM, CHIP or TANF Children Aged 0-1	\$396.03	\$279.32	41.8%												
PLM, CHIP or TANF Children Aged 1-5	\$65.49	\$56.03	16.9%												
PLM, CHIP or TANF Children Aged 6-18	\$62.26	\$54.92	13.4%												
OHP Families	\$159.25	\$163.65	-2.7%												
OHP Adults and Couples	\$262.15	\$242.21	8.2%												
AB/AD with Medicare	\$299.46	\$357.60	-16.3%												
AB/AD without Medicare	\$562.19	\$497.97	12.9%												
OAA with Medicare	\$263.79	\$334.49	-21.1%												
OAA without Medicare	\$544.23	\$603.44	-9.8%												
SCF Children	\$102.61	\$107.71	-4.7%												
Weighted Average	\$198.33	\$196.90	0.7%												

**Notes:**

The composition of several eligibility categories changed for FY 03/04. Specifically, TANF reflects adults only, and the TANF children have been moved with the PLM and CHIP children. General Assistance has been eliminated.

The FY 2004 capitation rates exclude maternity-related services as maternity will be paid on a case rate basis.

**Oregon Health Plan Medicaid Demonstration**  
**Comparison of FY 2004 and FY 2003 Physical Health Capitation Rates**  
**Including Administration**

**Exhibit 3e**

Providence Health Plan, Inc.															
Eligibility Category	JJD			Lane			LBMPY			Other			Tri-Counties		
	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change
TANF							\$222.46	\$138.08	61.1%				\$212.39	\$140.24	51.4%
General Assistance							N/A	\$688.57	N/A				N/A	\$695.96	N/A
PLM Adults							\$228.35	\$661.32	-65.5%				\$219.06	\$662.42	-66.9%
PLM, CHIP or TANF Children Aged 0-1							\$367.24	\$284.65	29.0%				\$322.19	\$281.73	14.4%
PLM, CHIP or TANF Children Aged 1-5							\$71.38	\$55.05	29.7%				\$68.53	\$56.60	21.1%
PLM, CHIP or TANF Children Aged 6-18							\$53.29	\$54.22	-1.7%				\$51.26	\$55.43	-7.5%
OHP Families							\$149.33	\$161.95	-7.8%				\$141.36	\$165.22	-14.4%
OHP Adults and Couples							\$387.75	\$273.26	41.9%				\$360.23	\$277.45	29.8%
AB/AD with Medicare							\$369.71	\$352.38	4.9%				\$367.19	\$359.84	2.0%
AB/AD without Medicare							\$724.01	\$514.19	40.8%				\$678.46	\$519.58	30.6%
OAA with Medicare							\$266.81	\$330.22	-19.2%				\$263.89	\$336.43	-21.6%
OAA without Medicare							\$589.92	\$593.67	-0.6%				\$543.26	\$609.98	-10.9%
SCF Children							\$105.83	\$106.63	-0.8%				\$102.68	\$108.53	-5.4%
Weighted Average							\$187.56	\$169.27	10.8%				\$230.39	\$217.79	5.8%

**Notes:**

The composition of several eligibility categories changed for FY 03/04. Specifically, TANF reflects adults only, and the TANF children have been moved with the PLM and CHIP children. General Assistance has been eliminated.

The FY 2004 capitation rates exclude maternity-related services as maternity will be paid on a case rate basis.

**Oregon Health Plan Medicaid Demonstration**  
**Comparison of FY 2004 and FY 2003 Physical Health Capitation Rates**  
**Including Administration**

**Exhibit 3e**

Tuality Health Alliance															
Eligibility Category	JJD			Lane			LBMPY			Other			Tri-Counties		
	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change
TANF													\$240.47	\$133.29	80.4%
General Assistance													N/A	\$663.85	N/A
PLM Adults													\$219.26	\$662.74	-66.9%
PLM, CHIP or TANF Children Aged 0-1													\$336.03	\$281.92	19.2%
PLM, CHIP or TANF Children Aged 1-5													\$67.52	\$56.60	19.3%
PLM, CHIP or TANF Children Aged 6-18													\$57.95	\$55.43	4.5%
OHP Families													N/A	\$163.75	N/A
OHP Adults and Couples													N/A	\$280.26	N/A
AB/AD with Medicare													\$316.44	\$358.51	-11.7%
AB/AD without Medicare													\$583.44	\$504.44	15.7%
OAA with Medicare													\$263.96	\$336.43	-21.5%
OAA without Medicare													\$544.14	\$610.07	-10.8%
SCF Children													\$102.75	\$108.54	-5.3%
Weighted Average													\$158.54	\$168.94	-6.2%

**Notes:**

The composition of several eligibility categories changed for FY 03/04. Specifically, TANF reflects adults only, and the TANF children have been moved with the PLM and CHIP children. General Assistance has been eliminated.

The FY 2004 capitation rates exclude maternity-related services as maternity will be paid on a case rate basis.

**Oregon Health Plan Medicaid Demonstration**  
**FY 2004 Capitation Rates**  
**MHO Geographic Factors**

**Exhibit 4a**

<b>Plan Name</b>	<b>Region</b>	<b>MH Inpatient</b>
Accountable Behavioral Health Alliance	Linn/Benton/Marion/Polk/Yamhill	1.0017
Accountable Behavioral Health Alliance	Other	1.0193
Clackamas County Mental Health	Other	1.0899
Clackamas County Mental Health	Tri-County (Clackamas, Multnomah, Washington)	0.9971
FamilyCare, Inc.	Tri-County (Clackamas, Multnomah, Washington)	0.9971
Greater Oregon Behavioral Health, Inc.	Other	0.9942
Jefferson Behavioral Health	Jackson/Josephine/Douglas	0.9808
Jefferson Behavioral Health	Other	0.9939
LaneCare	Lane	1.0116
Mid-Valley Behavioral Care Network	Linn/Benton/Marion/Polk/Yamhill	1.0035
Mid-Valley Behavioral Care Network	Other	1.0002
Multnomah CAAPCare	Tri-County (Clackamas, Multnomah, Washington)	0.9971
Tuality Health Alliance	Tri-County (Clackamas, Multnomah, Washington)	0.9974
Washington County DHHS	Tri-County (Clackamas, Multnomah, Washington)	0.9969

**Oregon Health Plan Medicaid Demonstration  
 FY 2004 Capitation Rates  
 MHO Residential Medical Adjustment for SCF Children**

**Exhibit 4b**

<b>Plan Name</b>	<b>Region</b>	<b>ResMed Factor</b>
Accountable Behavioral Health Alliance	Linn/Benton/Marion/Polk/Yamhill	0.9358
Accountable Behavioral Health Alliance	Other	0.9358
Clackamas County Mental Health	Other	1.1966
Clackamas County Mental Health	Tri-County (Clackamas, Multnomah, Washington)	0.9358
FamilyCare, Inc.	Tri-County (Clackamas, Multnomah, Washington)	0.9358
Greater Oregon Behavioral Health, Inc.	Other	0.9358
Jefferson Behavioral Health	Jackson/Josephine/Douglas	1.0346
Jefferson Behavioral Health	Other	0.9358
LaneCare	Lane	0.9774
Mid-Valley Behavioral Care Network	Linn/Benton/Marion/Polk/Yamhill	0.9358
Mid-Valley Behavioral Care Network	Other	0.9358
Multnomah CAAPCare	Tri-County (Clackamas, Multnomah, Washington)	1.0548
Tuality Health Alliance	Tri-County (Clackamas, Multnomah, Washington)	0.9358
Washington County DHHS	Tri-County (Clackamas, Multnomah, Washington)	1.2446

**Oregon Health Plan Medicaid Demonstration  
Comparison of FY 2004 and FY 2003 Mental Health Capitation Rates  
Including Administration**

**Exhibit 4c**

<b>Statewide MHO Rates</b>			
<b>Eligibility Category</b>	<b>FY 2004</b>	<b>FY 2003</b>	<b>% Change</b>
TANF	\$24.93	\$16.88	48%
General Assistance	N/A	\$203.56	N/A
PLM Adults	\$6.86	\$5.60	22.6%
PLM, CHIP or TANF Children Aged 0-1	\$0.66	\$0.03	2478.7%
PLM, CHIP or TANF Children Aged 1-5	\$4.50	\$12.41	-63.8%
PLM, CHIP or TANF Children Aged 6-18	\$17.65	\$12.33	43.2%
OHP Families	N/A	\$9.98	N/A
OHP Adults and Couples	N/A	\$26.51	N/A
AB/AD with Medicare	\$70.42	\$134.71	-47.7%
AB/AD without Medicare	\$114.77	\$115.65	-0.8%
OAA with Medicare	\$8.82	\$10.15	-13.1%
OAA without Medicare	\$8.17	\$44.36	-81.6%
SCF Children	\$117.13	\$131.31	-10.8%
<b>Weighted Average - June 2003 population</b>	<b>\$33.19</b>	<b>\$39.59</b>	<b>-16.2%</b>

**Notes:**

The composition of several eligibility categories changed for FY 03/04. Specifically, TANF reflects adults only, and the TANF children have been moved with the PLM and CHIP children. General Assistance has been eliminated.

Acute inpatient hospital care is the only mental health services are covered for the OHP Standard population. Since MHOs are not contracted for OHP Standard for FY 2004, the FY 2003 capitation rates for OHP Families and OHP Adults and Couples are shown for informational purposes only and do not contribute to the weighted average capitation rates shown in this exhibit.

**Oregon Health Plan Medicaid Demonstration**  
**Comparison of FY 2004 and FY 2003 Mental Health Capitation Rates**  
**Including Administration**

Exhibit 4c

Accountable Behavioral Health Alliance															
Eligibility Category	JJD			Lane			LBMPY			Other			Tri-Counties		
	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change
TANF							\$24.94	\$16.90	47.5%	\$25.01	\$16.90	48.0%			
General Assistance							N/A	\$203.94	N/A	N/A	\$203.85	N/A			
PLM Adults							\$6.86	\$5.61	22.4%	\$6.88	\$5.60	22.8%			
PLM, CHIP or TANF Children Aged 0-1							\$0.66	\$0.03	2478.7%	\$0.66	\$0.03	2478.7%			
PLM, CHIP or TANF Children Aged 1-5							\$4.50	\$12.41	-63.8%	\$4.50	\$12.41	-63.7%			
PLM, CHIP or TANF Children Aged 6-18							\$17.66	\$12.34	43.1%	\$17.70	\$12.34	43.5%			
OHP Families							N/A	\$10.01	N/A	N/A	\$10.00	N/A			
OHP Adults and Couples							N/A	\$26.58	N/A	N/A	\$26.56	N/A			
AB/AD with Medicare							\$70.42	\$134.87	-47.8%	\$70.48	\$134.83	-47.7%			
AB/AD without Medicare							\$114.83	\$115.88	-0.9%	\$115.42	\$115.83	-0.4%			
OAA with Medicare							\$8.82	\$10.16	-13.2%	\$8.83	\$10.16	-13.1%			
OAA without Medicare							\$8.17	\$44.38	-81.6%	\$8.18	\$44.37	-81.6%			
SCF Children							\$109.64	\$123.05	-10.9%	\$109.90	\$123.03	-10.7%			
Weighted Average							\$33.61	\$40.62	-17.3%	\$30.98	\$36.36	-14.8%			

**Notes:**

The composition of several eligibility categories changed for FY 03/04. Specifically, TANF reflects adults only, and the TANF children have been moved with the PLM and CHIP children. General Assistance has been eliminated.

Acute inpatient hospital care is the only mental health services are covered for the OHP Standard population. Since MHOs are not contracted for OHP Standard for FY 2004, the FY 2003 capitation rates for OHP Families and OHP Adults and Couples are shown for informational purposes only and do not contribute to the weighted average capitation rates shown in this exhibit.

**Oregon Health Plan Medicaid Demonstration**  
**Comparison of FY 2004 and FY 2003 Mental Health Capitation Rates**  
**Including Administration**

**Exhibit 4c**

<b>Multnomah CAAPCare</b>															
<b>Eligibility Category</b>	<b>JJD</b>			<b>Lane</b>			<b>LBMPY</b>			<b>Other</b>			<b>Tri-Counties</b>		
	<b>FY 2004</b>	<b>FY 2003</b>	<b>% Change</b>	<b>FY 2004</b>	<b>FY 2003</b>	<b>% Change</b>	<b>FY 2004</b>	<b>FY 2003</b>	<b>% Change</b>	<b>FY 2004</b>	<b>FY 2003</b>	<b>% Change</b>	<b>FY 2004</b>	<b>FY 2003</b>	<b>% Change</b>
TANF													\$24.91	\$16.89	47.5%
General Assistance													N/A	\$203.67	N/A
PLM Adults													\$6.86	\$5.60	22.5%
PLM, CHIP or TANF Children Aged 0-1													\$0.66	\$0.03	2478.7%
PLM, CHIP or TANF Children Aged 1-5													\$4.50	\$12.41	-63.8%
PLM, CHIP or TANF Children Aged 6-18													\$17.65	\$12.33	43.1%
OHP Families													N/A	\$9.99	N/A
OHP Adults and Couples													N/A	\$26.53	N/A
AB/AD with Medicare													\$70.41	\$134.76	-47.8%
AB/AD without Medicare													\$114.67	\$115.72	-0.9%
OAA with Medicare													\$8.82	\$10.16	-13.2%
OAA without Medicare													\$8.16	\$44.37	-81.6%
SCF Children													\$123.51	\$137.19	-10.0%
Weighted Average													\$36.49	\$44.31	-17.7%

**Notes:**  
The composition of several eligibility categories changed for FY 03/04. Specifically, TANF reflects adults only, and the TANF children have been moved with the PLM and CHIP children. General Assistance has been eliminated.

Acute inpatient hospital care is the only mental health services are covered for the OHP Standard population. Since MHOs are not contracted for OHP Standard for FY 2004, the FY 2003 capitation rates for OHP Families and OHP Adults and Couples are shown for informational purposes only and do not contribute to the weighted average capitation rates shown in this exhibit.

**Oregon Health Plan Medicaid Demonstration**  
**Comparison of FY 2004 and FY 2003 Mental Health Capitation Rates**  
**Including Administration**

**Exhibit 4c**

<b>Clackamas County Mental Health</b>															
<b>Eligibility Category</b>	<b>JJD</b>			<b>Lane</b>			<b>LBMPY</b>			<b>Other</b>			<b>Tri-Counties</b>		
	<b>FY 2004</b>	<b>FY 2003</b>	<b>% Change</b>	<b>FY 2004</b>	<b>FY 2003</b>	<b>% Change</b>	<b>FY 2004</b>	<b>FY 2003</b>	<b>% Change</b>	<b>FY 2004</b>	<b>FY 2003</b>	<b>% Change</b>	<b>FY 2004</b>	<b>FY 2003</b>	<b>% Change</b>
TANF										\$25.32	\$16.90	49.8%	\$24.91	\$16.89	47.5%
General Assistance										N/A	\$203.99	N/A	N/A	\$203.68	N/A
PLM Adults										\$6.94	\$5.61	23.8%	\$6.86	\$5.60	22.5%
PLM, CHIP or TANF Children Aged 0-1										\$0.66	\$0.03	2478.7%	\$0.66	\$0.03	2478.7%
PLM, CHIP or TANF Children Aged 1-5										\$4.51	\$12.41	-63.7%	\$4.50	\$12.41	-63.8%
PLM, CHIP or TANF Children Aged 6-18										\$17.89	\$12.34	44.9%	\$17.65	\$12.33	43.1%
OHP Families										N/A	\$10.01	N/A	N/A	\$9.99	N/A
OHP Adults and Couples										N/A	\$26.59	N/A	N/A	\$26.53	N/A
AB/AD with Medicare										\$70.72	\$134.89	-47.6%	\$70.41	\$134.76	-47.8%
AB/AD without Medicare										\$117.83	\$115.92	1.6%	\$114.67	\$115.72	-0.9%
OAA with Medicare										\$8.87	\$10.16	-12.7%	\$8.82	\$10.16	-13.2%
OAA without Medicare										\$8.22	\$44.38	-81.5%	\$8.16	\$44.37	-81.6%
SCF Children										\$141.87	\$160.29	-11.5%	\$109.57	\$122.98	-10.9%
Weighted Average										\$29.23	\$34.33	-14.9%	\$33.76	\$40.85	-17.3%

**Notes:**

The composition of several eligibility categories changed for FY 03/04. Specifically, TANF reflects adults only, and the TANF children have been moved with the PLM and CHIP children. General Assistance has been eliminated.

Acute inpatient hospital care is the only mental health services are covered for the OHP Standard population. Since MHOs are not contracted for OHP Standard for FY 2004, the FY 2003 capitation rates for OHP Families and OHP Adults and Couples are shown for informational purposes only and do not contribute to the weighted average capitation rates shown in this exhibit.

**Oregon Health Plan Medicaid Demonstration**  
**Comparison of FY 2004 and FY 2003 Mental Health Capitation Rates**  
**Including Administration**

**Exhibit 4c**

FamilyCare, Inc.															
Eligibility Category	JJD			Lane			LBMPY			Other			Tri-Counties		
	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change
TANF													\$24.91	\$16.89	47.5%
General Assistance													N/A	\$203.68	N/A
PLM Adults													\$6.86	\$5.60	22.5%
PLM, CHIP or TANF Children Aged 0-1													\$0.66	\$0.03	2478.7%
PLM, CHIP or TANF Children Aged 1-5													\$4.50	\$12.41	-63.8%
PLM, CHIP or TANF Children Aged 6-18													\$17.65	\$12.33	43.1%
OHP Families													N/A	\$9.99	N/A
OHP Adults and Couples													N/A	\$26.53	N/A
AB/AD with Medicare													\$70.41	\$134.76	-47.8%
AB/AD without Medicare													\$114.67	\$115.72	-0.9%
OAA with Medicare													\$8.82	\$10.16	-13.2%
OAA without Medicare													\$8.16	\$44.37	-81.6%
SCF Children													\$109.57	\$122.98	-10.9%
Weighted Average													\$26.40	\$30.25	-12.7%

**Notes:**  
The composition of several eligibility categories changed for FY 03/04. Specifically, TANF reflects adults only, and the TANF children have been moved with the PLM and CHIP children. General Assistance has been eliminated.

Acute inpatient hospital care is the only mental health services are covered for the OHP Standard population. Since MHOs are not contracted for OHP Standard for FY 2004, the FY 2003 capitation rates for OHP Families and OHP Adults and Couples are shown for informational purposes only and do not contribute to the weighted average capitation rates shown in this exhibit.

**Oregon Health Plan Medicaid Demonstration**  
**Comparison of FY 2004 and FY 2003 Mental Health Capitation Rates**  
**Including Administration**

Exhibit 4c

Greater Oregon Behavioral Health, Inc.															
Eligibility Category	JJD			Lane			LBMPY			Other			Tri-Counties		
	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change
TANF										\$24.90	\$16.85	47.8%			
General Assistance										N/A	\$202.79	N/A			
PLM Adults										\$6.86	\$5.59	22.8%			
PLM, CHIP or TANF Children Aged 0-1										\$0.66	\$0.03	2478.7%			
PLM, CHIP or TANF Children Aged 1-5										\$4.50	\$12.40	-63.7%			
PLM, CHIP or TANF Children Aged 6-18										\$17.64	\$12.30	43.3%			
OHP Families										N/A	\$9.94	N/A			
OHP Adults and Couples										N/A	\$26.36	N/A			
AB/AD with Medicare										\$70.40	\$134.39	-47.6%			
AB/AD without Medicare										\$114.57	\$115.17	-0.5%			
OAA with Medicare										\$8.82	\$10.14	-13.0%			
OAA without Medicare										\$8.16	\$44.33	-81.6%			
SCF Children										\$109.53	\$122.73	-10.8%			
Weighted Average										\$32.32	\$38.22	-15.4%			

**Notes:**

The composition of several eligibility categories changed for FY 03/04. Specifically, TANF reflects adults only, and the TANF children have been moved with the PLM and CHIP children. General Assistance has been eliminated.

Acute inpatient hospital care is the only mental health services are covered for the OHP Standard population. Since MHOs are not contracted for OHP Standard for FY 2004, the FY 2003 capitation rates for OHP Families and OHP Adults and Couples are shown for informational purposes only and do not contribute to the weighted average capitation rates shown in this exhibit.

**Oregon Health Plan Medicaid Demonstration**  
**Comparison of FY 2004 and FY 2003 Mental Health Capitation Rates**  
**Including Administration**

Exhibit 4c

Jefferson Behavioral Health															
Eligibility Category	JJD			Lane			LBMPY			Other			Tri-Counties		
	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change
TANF	\$24.84	\$16.85	47.5%							\$24.90	\$16.88	47.5%			
General Assistance	N/A	\$202.73	N/A							N/A	\$203.42	N/A			
PLM Adults	\$6.84	\$5.58	22.6%							\$6.86	\$5.60	22.5%			
PLM, CHIP or TANF Children Aged 0-1	\$0.66	\$0.03	2478.7%							\$0.66	\$0.03	2478.7%			
PLM, CHIP or TANF Children Aged 1-5	\$4.49	\$12.40	-63.8%							\$4.50	\$12.40	-63.8%			
PLM, CHIP or TANF Children Aged 6-18	\$17.60	\$12.30	43.1%							\$17.64	\$12.32	43.1%			
OHP Families	N/A	\$9.94	N/A							N/A	\$9.98	N/A			
OHP Adults and Couples	N/A	\$26.35	N/A							N/A	\$26.48	N/A			
AB/AD with Medicare	\$70.35	\$134.36	-47.6%							\$70.40	\$134.65	-47.7%			
AB/AD without Medicare	\$114.11	\$115.13	-0.9%							\$114.56	\$115.56	-0.9%			
OAA with Medicare	\$8.81	\$10.14	-13.1%							\$8.82	\$10.15	-13.1%			
OAA without Medicare	\$8.15	\$44.32	-81.6%							\$8.16	\$44.36	-81.6%			
SCF Children	\$120.88	\$136.78	-11.6%							\$109.52	\$122.91	-10.9%			
Weighted Average	\$33.25	\$39.25	-15.3%							\$37.33	\$44.12	-15.4%			

**Notes:**

The composition of several eligibility categories changed for FY 03/04. Specifically, TANF reflects adults only, and the TANF children have been moved with the PLM and CHIP children. General Assistance has been eliminated.

Acute inpatient hospital care is the only mental health services are covered for the OHP Standard population. Since MHOs are not contracted for OHP Standard for FY 2004, the FY 2003 capitation rates for OHP Families and OHP Adults and Couples are shown for informational purposes only and do not contribute to the weighted average capitation rates shown in this exhibit.



**Oregon Health Plan Medicaid Demonstration**  
**Comparison of FY 2004 and FY 2003 Mental Health Capitation Rates**  
**Including Administration**

Exhibit 4c

Mid-Valley Behavioral Care Network															
Eligibility Category	JJD			Lane			LBMPY			Other			Tri-Counties		
	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change
TANF							\$24.94	\$16.90	47.6%	\$24.93	\$16.90	47.5%			
General Assistance							N/A	\$203.81	N/A	N/A	\$203.81	N/A			
PLM Adults							\$6.86	\$5.60	22.5%	\$6.86	\$5.60	22.5%			
PLM, CHIP or TANF Children Aged 0-1							\$0.66	\$0.03	2478.7%	\$0.66	\$0.03	2478.7%			
PLM, CHIP or TANF Children Aged 1-5							\$4.50	\$12.41	-63.8%	\$4.50	\$12.41	-63.8%			
PLM, CHIP or TANF Children Aged 6-18							\$17.66	\$12.34	43.2%	\$17.65	\$12.34	43.1%			
OHP Families							N/A	\$10.00	N/A	N/A	\$10.00	N/A			
OHP Adults and Couples							N/A	\$26.55	N/A	N/A	\$26.55	N/A			
AB/AD with Medicare							\$70.43	\$134.82	-47.8%	\$70.42	\$134.81	-47.8%			
AB/AD without Medicare							\$114.89	\$115.80	-0.8%	\$114.77	\$115.80	-0.9%			
OAA with Medicare							\$8.82	\$10.16	-13.1%	\$8.82	\$10.16	-13.2%			
OAA without Medicare							\$8.17	\$44.37	-81.6%	\$8.17	\$44.37	-81.6%			
SCF Children							\$109.67	\$123.01	-10.8%	\$109.62	\$123.01	-10.9%			
Weighted Average							\$30.53	\$36.34	-16.0%	\$31.47	\$37.82	-16.8%			

**Notes:**

The composition of several eligibility categories changed for FY 03/04. Specifically, TANF reflects adults only, and the TANF children have been moved with the PLM and CHIP children. General Assistance has been eliminated.

Acute inpatient hospital care is the only mental health services are covered for the OHP Standard population. Since MHOs are not contracted for OHP Standard for FY 2004, the FY 2003 capitation rates for OHP Families and OHP Adults and Couples are shown for informational purposes only and do not contribute to the weighted average capitation rates shown in this exhibit.

**Oregon Health Plan Medicaid Demonstration**  
**Comparison of FY 2004 and FY 2003 Mental Health Capitation Rates**  
**Including Administration**

**Exhibit 4c**

<b>Tuality Health Alliance</b>															
<b>Eligibility Category</b>	<b>JJD</b>			<b>Lane</b>			<b>LBMPY</b>			<b>Other</b>			<b>Tri-Counties</b>		
	<b>FY 2004</b>	<b>FY 2003</b>	<b>% Change</b>	<b>FY 2004</b>	<b>FY 2003</b>	<b>% Change</b>	<b>FY 2004</b>	<b>FY 2003</b>	<b>% Change</b>	<b>FY 2004</b>	<b>FY 2003</b>	<b>% Change</b>	<b>FY 2004</b>	<b>FY 2003</b>	<b>% Change</b>
TANF													\$24.92	\$16.89	47.5%
General Assistance													N/A	\$203.69	N/A
PLM Adults													\$6.86	\$5.60	22.5%
PLM, CHIP or TANF Children Aged 0-1													\$0.66	\$0.03	2478.7%
PLM, CHIP or TANF Children Aged 1-5													\$4.50	\$12.41	-63.8%
PLM, CHIP or TANF Children Aged 6-18													\$17.65	\$12.33	43.1%
OHP Families													N/A	\$9.99	N/A
OHP Adults and Couples													N/A	\$26.53	N/A
AB/AD with Medicare													\$70.41	\$134.76	-47.8%
AB/AD without Medicare													\$114.68	\$115.73	-0.9%
OAA with Medicare													\$8.82	\$10.16	-13.2%
OAA without Medicare													\$8.16	\$44.37	-81.6%
SCF Children													\$109.58	\$122.98	-10.9%
Weighted Average													\$24.68	\$28.32	-12.8%

**Notes:**

The composition of several eligibility categories changed for FY 03/04. Specifically, TANF reflects adults only, and the TANF children have been moved with the PLM and CHIP children. General Assistance has been eliminated.

Acute inpatient hospital care is the only mental health services are covered for the OHP Standard population. Since MHOs are not contracted for OHP Standard for FY 2004, the FY 2003 capitation rates for OHP Families and OHP Adults and Couples are shown for informational purposes only and do not contribute to the weighted average capitation rates shown in this exhibit.

**Oregon Health Plan Medicaid Demonstration**  
**Comparison of FY 2004 and FY 2003 Mental Health Capitation Rates**  
**Including Administration**

**Exhibit 4c**

Washington County Health and Human Services															
Eligibility Category	JJD			Lane			LBMPY			Other			Tri-Counties		
	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change
TANF													\$24.91	\$16.89	47.5%
General Assistance													N/A	\$203.69	N/A
PLM Adults													\$6.86	\$5.60	22.5%
PLM, CHIP or TANF Children Aged 0-1													\$0.66	\$0.03	2478.7%
PLM, CHIP or TANF Children Aged 1-5													\$4.50	\$12.41	-63.8%
PLM, CHIP or TANF Children Aged 6-18													\$17.65	\$12.33	43.1%
OHP Families													N/A	\$9.99	N/A
OHP Adults and Couples													N/A	\$26.53	N/A
AB/AD with Medicare													\$70.41	\$134.76	-47.8%
AB/AD without Medicare													\$114.66	\$115.73	-0.9%
OAA with Medicare													\$8.82	\$10.16	-13.2%
OAA without Medicare													\$8.16	\$44.37	-81.6%
SCF Children													\$145.73	\$173.22	-15.9%
Weighted Average													\$29.79	\$36.20	-17.7%

**Notes:**  
The composition of several eligibility categories changed for FY 03/04. Specifically, TANF reflects adults only, and the TANF children have been moved with the PLM and CHIP children. General Assistance has been eliminated.

Acute inpatient hospital care is the only mental health services are covered for the OHP Standard population. Since MHOs are not contracted for OHP Standard for FY 2004, the FY 2003 capitation rates for OHP Families and OHP Adults and Couples are shown for informational purposes only and do not contribute to the weighted average capitation rates shown in this exhibit.

**Oregon Health Plan Medicaid Demonstration  
Comparison of FY 2004 and FY 2003 Dental Capitation Rates  
Including Administration**

**Exhibit 5**

<b>Statewide DCO Rates</b>			
<b>Eligibility Category</b>	<b>FY 2004</b>	<b>FY 2003</b>	<b>% Change</b>
TANF	\$29.86	\$18.52	61%
General Assistance	N/A	\$33.69	N/A
PLM Adults	\$15.13	\$17.67	-14.4%
PLM, CHIP or TANF Children Aged 0-1	\$0.09	\$0.09	4.4%
PLM, CHIP or TANF Children Aged 1-5	\$13.01	\$16.44	-20.9%
PLM, CHIP or TANF Children Aged 6-18	\$19.38	\$20.23	-4.2%
OHP Families	N/A	\$29.77	N/A
OHP Adults and Couples	N/A	\$35.21	N/A
AB/AD with Medicare	\$25.46	\$21.61	17.8%
AB/AD without Medicare	\$23.56	\$20.99	12.2%
OAA with Medicare	\$16.32	\$13.73	18.9%
OAA without Medicare	\$27.25	\$56.68	-51.9%
SCF Children	\$18.65	\$16.20	15.2%
Weighted Average - June 2003 population	\$18.63	\$18.01	3.5%

**Notes:**

**The composition of several eligibility categories changed for FY 03/04. Specifically, TANF reflects adults only, and the TANF children have been moved with the PLM and CHIP children. General Assistance has been eliminated.**

**Only limited Dental services are covered for the OHP Standard population. Since DCOs are not contracted for OHP Standard for FY 2004, the FY 2003 capitation rates for OHP Families and OHP Adults and Couples are shown for informational purposes only and do not contribute to the weighted average capitation rates shown in this exhibit.**

Exhibits 2004  
State Dental  
10/1/2003

**Oregon Health Plan Medicaid Demonstration**  
**Comparison of FY 2004 and FY 2003 Dental Capitation Rates**  
**Including Administration**

**Exhibit 5**

Eligibility Category	Dental														
	JJD			Lane			LBMPY			Other			Tri-County		
	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change	FY 2004	FY 2003	% Change
TANF	\$28.93	\$17.95	61.11%	\$28.93	\$17.95	61.11%	\$28.93	\$17.95	61.11%	\$28.93	\$17.95	61.11%	\$31.49	\$19.36	62.63%
General Assistance	N/A	\$32.67	N/A	N/A	\$35.23	N/A									
PLM Adults	\$14.66	\$17.13	-14.45%	\$14.66	\$17.13	-14.45%	\$14.66	\$17.13	-14.45%	\$14.66	\$17.13	-14.45%	\$15.95	\$18.47	-13.64%
PLM, CHIP or TANF Children Aged 0-1	\$0.09	\$0.09	4.26%	\$0.09	\$0.09	4.26%	\$0.09	\$0.09	4.26%	\$0.09	\$0.09	4.26%	\$0.10	\$0.09	5.24%
PLM, CHIP or TANF Children Aged 1-5	\$12.60	\$15.94	-20.97%	\$12.60	\$15.94	-20.97%	\$12.60	\$15.94	-20.97%	\$12.60	\$15.94	-20.97%	\$13.71	\$17.19	-20.22%
PLM, CHIP or TANF Children Aged 6-18	\$18.77	\$19.62	-4.31%	\$18.77	\$19.62	-4.31%	\$18.77	\$19.62	-4.31%	\$18.77	\$19.62	-4.31%	\$20.43	\$21.15	-3.41%
OHP Families	N/A	\$28.86	N/A	N/A	\$31.12	N/A									
OHP Adults and Couples	N/A	\$34.14	N/A	N/A	\$36.81	N/A									
AB/AD with Medicare	\$24.66	\$20.96	17.68%	\$24.66	\$20.96	17.68%	\$24.66	\$20.96	17.68%	\$24.66	\$20.96	17.68%	\$26.84	\$22.60	18.79%
AB/AD without Medicare	\$22.82	\$20.35	12.13%	\$22.82	\$20.35	12.13%	\$22.82	\$20.35	12.13%	\$22.82	\$20.35	12.13%	\$24.84	\$21.95	13.19%
OAA with Medicare	\$15.80	\$13.31	18.75%	\$15.80	\$13.31	18.75%	\$15.80	\$13.31	18.75%	\$15.80	\$13.31	18.75%	\$17.20	\$14.35	19.87%
OAA without Medicare	\$26.40	\$54.95	-51.96%	\$26.40	\$54.95	-51.96%	\$26.40	\$54.95	-51.96%	\$26.40	\$54.95	-51.96%	\$28.73	\$59.26	-51.51%
SCF Children	\$18.07	\$15.71	15.05%	\$18.07	\$15.71	15.05%	\$18.07	\$15.71	15.05%	\$18.07	\$15.71	15.05%	\$19.67	\$16.93	16.14%
Weighted Average:	\$18.41	\$17.62	4.45%	\$18.52	\$17.61	5.17%	\$17.77	\$17.32	2.60%	\$18.15	\$17.46	3.93%	\$19.47	\$18.81	3.52%

**Notes:**

The composition of several eligibility categories changed for FY 03/04. Specifically, TANF reflects adults only, and the TANF children have been moved with the PLM and CHIP children. General Assistance has been eliminated.

Only limited Dental services are covered for the OHP Standard population. Since DCOs are not contracted for OHP Standard for FY 2004, the FY 2003 capitation rates for OHP Families and OHP Adults and Couples are shown for informational purposes only and do not contribute to the weighted average capitation rates shown in this exhibit.

**Oregon Health Plan Medicaid Demonstration**  
**Comparison of FY 2004 and FY 2003 Chemical Dependency Capitation Rates**  
**Including Administration**

**Exhibit 6**

<b>CDO Rates</b>			
<b>Eligibility Category</b>	<b>FY 2004</b>	<b>FY 2003</b>	<b>% Change</b>
TANF	\$11.64	\$4.10	184%
General Assistance	N/A	\$19.64	N/A
PLM Adults	\$4.77	\$2.85	67.4%
PLM, CHIP or TANF Children Aged 0-1	\$0.00	\$0.00	-83.1%
PLM, CHIP or TANF Children Aged 1-5	\$0.00	\$0.01	-51.2%
PLM, CHIP or TANF Children Aged 6-18	\$1.18	\$1.00	18.1%
OHP Families	N/A	\$3.74	N/A
OHP Adults and Couples	N/A	\$14.25	N/A
AB/AD with Medicare	\$3.80	\$2.09	81.7%
AB/AD without Medicare	\$6.50	\$2.53	157.0%
OAA with Medicare	\$0.16	\$0.05	188.6%
OAA without Medicare	\$0.03	\$0.01	383.2%
SCF Children	\$4.77	\$7.11	-32.8%
Weighted Average - June 2003 population	\$2.94	\$2.37	23.8%

**Notes:**

The composition of several eligibility categories changed for FY 03/04. Specifically, TANF reflects adults only, and the TANF children have been moved with the PLM and CHIP children. General Assistance has been eliminated.

Chemical Dependency services are not covered for the OHP Standard population. The FY 2003 capitation rates for OHP Families and OHP Adults and Couples are shown for informational purposes only and do not contribute to the weighted average capitation rates shown in this exhibit.

# APPENDIX



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to: **Maureen King**  
from: **Peter Davidson**

date: **August 6, 2003**  
subject: **Prioritized List Changes**

We have reviewed modifications to the Prioritized List of Services approved by the Health Services Commission to assess whether the changes are likely to result in an increase or decrease in costs to health plans of more than 1%. The HSC has made numerous technical changes to the List largely resulting from the annual updating of the Current Procedural Terminology and International Classification of Diseases lists, and efforts to “clean up” inappropriate pairings or improperly omitted pairings of codes.

The most significant coverage changes appear to be the following:

- Treatments of abscesses and other diseases of the lips (ID #544), abscesses and ulceration of the tongue (ID #545), and infected hydrocele (ID #548) are newly covered services at line 355; and
- Treatment of urethral caruncle (ID #560) is a newly non-covered service.

### Conclusions

Based on the relatively low costs of these procedures, we conclude that the cost or savings resulting from these changes will be below the 1% cost threshold that requires adjustment to health plan capitation rates. Based on our review of the other changes in the prioritized list, it appears that the total impact of the changes will also be below the 1% cost threshold.

\* \* \*

Please call me at 415/498-5636 or Sandi Hunt at 415/498-5365 if you have any questions regarding this memo.

**Oregon Health Plan Medicaid Demonstration  
 FY 2004 Capitation Rate Development  
 CMS Medicaid Managed Care Rate Setting Checklist – Crosswalk**

Item #	Legal Cite	Subject	Comments
AA.1.0	42 CFR 438.6(c)(2)(i) and (ii)  42 CFR 438.806  SMM 2089.2, SMM 2092.8 SMM 2089.1	<u>Overview of ratesetting methodology</u> - The Contract must specify the payment rates and any risk-sharing mechanisms and the actuarial basis for computation of those rates and mechanisms: Specifically, the contract includes: <ul style="list-style-type: none"> <li>___ The rates and the time period for the rates,</li> <li>___ The risk-sharing mechanisms,</li> <li>___ The actuarial basis for the computation of those rates and risk-sharing mechanisms (<i>a lay person’s description of the general steps the State followed to set rates is sufficient</i>).</li> </ul> <i>Rate Development or Update</i> <ul style="list-style-type: none"> <li>___ <i>The State is developing a new rate (RO completes steps AA.1 - AA.7).</i></li> <li>___ <i>The State is adjusting rates approved under 42 CFR 438.6(c)-(RO completes all of step AA.1)</i></li> </ul>	2004-2005 Per Capita Cost report and FY 2004 Capitation Rate report describe steps.
AA.1.1	42 CFR 438.6(c)(1)(i)(A) and (C)  42 CFR 438.6(2)(i) and (ii)  42 CFR 438.6(c)(3)  42 CFR 438.6(c)(4)(i)  SMM 2089.2	<u>Actuarial certification</u> -The State must provide the actuarial certification of the capitation rates and payments under the contract. All payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound. Actuarially sound capitation rates means capitation rates that have been developed in accordance with generally accepted actuarial principles and practices, are appropriate for the populations to be covered, and the services to be furnished under the contract; and the Actuary must submit a certification, as meeting the requirements of the regulation, by an actuary who meets the qualification standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board. <i>Note: An Actuary who is a member of the American Academy of Actuaries will sign his name followed by the designation M.A.A.A., meaning a Member of the American Academy of Actuaries. For further information see <a href="http://www.actuary.org/faqs.htm">www.actuary.org/faqs.htm</a></i>  <i>Note: Actuaries can create either rates or rate ranges so long as the methodology (including all assumptions) to get to the actual rates in the contract are specified and meet CMS requirements. If there are instances where actuaries believe that information their State is required to submit would represent trade secrets or proprietary information, as described in the Freedom of Information Act (FOIA) (5 U.S.C. 552(a)), the information should be identified as such and may be withheld from public disclosure under the provisions of the FOIA.</i>	Provided in FY 2004 Capitation Rate report
AA.1.2	42 CFR 438.6(c)(4)(iii)	<u>Projection of expenditures</u> -The State must provide a projection of expenditures under its previous year’s contract (or under its FFS program if it did not have a contract in the previous year) compared to those projected under the proposed contract.	Provided in the FY 2004 Capitation Rate report, Exhibits 3e, 4c, 5, and 6.
AA.1.3	45 CFR 74.43 and	<u>Procurement, Prior Approval and Ratesetting</u> - All contracts must meet the procurement	Contracting

Item #	Legal Cite	Subject	Comments
	Appendix A 42 CFR 438.6(a) 42 CFR 438.806(a) and (b)	requirements in 45 CFR Part 74. Regardless of the procurement method, the final rates must be in the contract and include documentation and a description of how the resulting contract rates are determined in sufficient detail to address this set of regulatory criteria for each contract. In general, there are two options: ___ Option 1: State set rates -- The rates are developed using a set of assumptions meeting federal regulations that results in a set of rates. Open cooperative contracting occurs when the State signs a contract with any entity meeting the technical programmatic requirements of the State and willing to be reimbursed the actuarially-sound, State-determined rate. Sole source contracting occurs where the state contracts with a single entity to provide a set of services must be documented as meeting the requirements of 42 CFR 438.6(c) under this option. ___ Option 2: Competitive Procurement -- The rates are developed using a set of assumptions meeting federal regulations that results in a range of acceptable bids to determine a bid range for rates. Competitive procurement occurs when entities submit bids and the State negotiates rates within the range of acceptable bids. <i>A State could also disclose a maximum or minimum acceptable payment and encourage bids below or above that amount.</i>	arrangements described on Page 7 of 2004-2005 Per Capita Cost report and Page 1 of FY 2004 Capitation Rate report
AA.1.5	42 CFR 447.15 42 CFR 438.2 42 CFR 438.812(a)	<u>Risk contracts</u> – The entity assumes risk for the cost of services covered under the contract and incurs loss if the cost of furnishing the services exceed the payments under the contract. The entity must accept as payment in full, the amount paid by the State plus any cost sharing from the members. Payments for carrying out contract provisions including incentive payments are medical assistance costs.	
AA.1.6	42 CFR 438.60	<u>Limit on payment to other providers</u> - The State agency must ensure that no payment is made to a provider other than the entity for services available under the contract between the State and the entity, except when these payments are provided for in title XIX of the Act, in 42 CFR, or when the State agency has adjusted the capitation rates paid under the contract to make payments for graduate medical education. <i>Note: see Step AA.3.8 for GME adjustments.</i>	Provided in the FY 2004 Capitation Rate report, Exhibit A-3.
AA.1.7	42 CFR 438.6(c)(4)(i) and (ii) 42 CFR 438.6(c)(2)(i) and (ii) 42 CFR 438.6(c)(1)(i)(A) and (C) 42 CFR 438.6(c)(3) 42 CFR	<u>Rate Modifications</u> - <i>This section is for use if the State updates or amends rates set under the new regulation at 42 CFR 438.6(c).</i> The State has made program and rate changes that have affected the cost and utilization under the contract. The value and effect of these programmatic service changes on the rates should be documented. Adjustments for changes in the program structure or to reflect Medical trend inflation are made. Documentation meeting the requirements in step AA.3.0 – AA.3.24 is submitted to the RO for new adjustments. The adjustments include but are not limited to: <ul style="list-style-type: none"> <li>• Medical cost and utilization trend inflation factors are based on historical medical State-specific costs or a national/regional medical market basket applicable to the state and population. Justification for the predictability of the inflation rates is given regardless of the source. Differentiation of trend rates is documented (i.e., differences in the trend by service categories, eligibility category, etc). All trend factors and assumptions are explained and documented. See Step AA.3.9.</li> <li>• Programmatic changes include additions and deletions to the contractor's benefit package, changes in the eligible population, or other programmatic changes in the managed care program (or FFS program that affected the managed care program) made after the last set of</li> </ul>	Not applicable.

Item #	Legal Cite	Subject	Comments
	<p>438.6(c)(4)(ii)(A)</p> <p>42 CFR 438.6(c)(1)(B)</p> <p>42 CFR 438.6(c)(3)(ii) and (iv)</p> <p>SMM 2089.5</p>	<p>rates were set and outlined in the regulation. The State may adjust for those changes if the adjustment is made only once (e.g., if the State projected the effect of a change in the last rate setting, then they must back out that projection before applying an adjustment for the actual policy effect)</p> <p>CMS allows rate changes (regardless of whether they are reductions or augmentations) and provides FFP in such changes as long as the changes are implemented through either a formal contract amendment or a multi-period contract and continue to meet all applicable statute provisions and regulations. If rate changes are implemented through a contract amendment, the amendment must receive approval by the RO before FFP in any higher payment amounts may be awarded. If the rate change is an anticipated development in a multi-year process, it must also be reviewed by the RO, consistent with guidelines for multi-year contracts. <i>If the amended rates use new actuarial techniques or different utilization data bases than was used and approved previously, the regional office should complete the entire checklist. Rates approved prior to the release of 42 CFR 438.6 must comply with the regulation by the period specified in the Federal Register.</i></p>	
AA.2.0	<p>42 CFR 438.6(c)(3)(i) and (iv)</p> <p>42 CFR 438.6(c)(1)(i)(B)</p>	<p><u>Base Year Utilization and Cost Data</u> - The State must provide documentation and an assurance that all payment rates are:</p> <ul style="list-style-type: none"> <li>• based only upon services covered under the State Plan (or costs directly related to providing these services, for example, MCO, PIHP, or PAHP administration)</li> <li>• Provided under the contract to Medicaid -eligible individuals.</li> </ul> <p>*In setting actuarially sound capitation rates, the State must apply the following element or explain why it is not applicable: Base utilization and cost data that are derived from the Medicaid population or if not, are adjusted to make them comparable to the Medicaid population. The base data used were recent and are free from material omission.</p> <p><i>Base data for both utilization and cost are defined and relevant to the Medicaid population (i.e., the database is appropriate for setting rates for the given Medicaid population). States without recent FFS history and no validated encounter data will need to develop other data sources for this purpose. States and their actuaries will have to decide which source of data to use for this purpose, based on which source is determined to have the highest degree of reliability, subject to RO approval.</i></p> <p><i>Examples of acceptable databases on which to base utilization assumptions are: Medicaid FFS databases, Medicaid managed care encounter data, State employees health insurance databases, and low-income health insurance program databases. Note: Some states have implemented financial reporting requirements of the health plans which can be used as a data source in conjunction with encounter data and would improve on some of the shortcomings of these other specific databases used for utilization purposes. For example, some states now require the submission of financial reports to supplement encounter data by providing cost data. It would also be permissible for the State to supplement the encounter data by using FFS cost data. The State could use the cost and</i></p>	<p>Data used in capitation rate development are from plan Medicaid encounter data (described starting on Page 9 of 2004-2005 Per Capita Cost report). It was validated by the plans as described on pages 9-11 of the 2004-2005 Per Capita Cost report and by the State. Invalid data was omitted (Page 9 and 10 of 2004-2005 Per Capita Cost report). Base data is shown in Exhibit 3 of 2004-2005 Per Capita Cost report.</p>

Item #	Legal Cite	Subject	Comments
		<p><i>utilization data from a Medicaid FFS database and would not need to supplement the data with plan financial information.</i></p> <p><i>Note: The CMS RO may approve other sources not listed here based upon the reasonableness of the given data source. The overall intent of these reporting requirements is to collect the same information that is available in the encounter data, but in a more complete and accurate reflection of the true cost of services.</i></p> <p><u>Utilization data</u> is appropriate to the Medicaid population and the base data was reviewed by the State for similarity with the covered Medicaid population. That is, if the utilization assumptions are not derived from recent Medicaid experience, the State should explain and document the source of assumptions and why the assumptions are appropriate to the Medicaid population covered by these proposed rates.</p> <p><u>Service cost</u> assumptions are appropriate for a Medicaid program and the base data was reviewed by the State for similarity with the Medicaid program’s current costs. <i>Note: except in the case of payments to FQHCs that subcontract with entities, which are governed by section 1903(m)(2)(A)(ix), CMS does not regulate the payment rates between entities and subcontracting providers. Payment rates are adequate to the extent that the capitated entity has documented the adequacy of its network.</i></p> <p><i>The term “appropriate” means specific to the population for which the payment rate is intended. This requirement applies to individuals who have health care costs that are much higher than the average. Appropriate for the populations covered means that the rates are based upon specific populations, by eligibility category, age, gender, locality, and other distinctions decided by the State. Appropriate to the services to be covered means that the rates must be based upon the State plan services to be provided under the contract. There is no stated or implied requirement that entities be reimbursed the full cost of care at billed charges.</i></p>	
AA.2.1	<p>42 CFR 438.6(c)(1)(i)(B)</p> <p>42 CFR 438.6(c)(4)(ii)(B)</p>	<p><u>Medicaid Eligibles under the Contract</u> – All payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound. Actuarially sound capitation rates means capitation rates are appropriate for the populations to be covered and provided under the contract to Medicaid -eligible individuals. <i>The State may either include only data for eligible individuals and exclude data for individuals in the base period who would not be eligible for managed care contract services or apply an appropriate adjustment factor to the data to remove ineligible if sufficient documentation exists. The explanation and documentation should list the eligibility categories specifically included and excluded from the analysis.</i></p> <p><i>Note: for example, if mentally retarded individuals are not in the managed care program, utilization, eligibility and cost data for mentally retarded eligibles should all be excluded from the rates.</i></p> <p><i>Note: all references in this checklist to Medicaid eligibles include 1115 expansion populations approved under 1115 demonstration projects.</i></p>	<p>Capitation rates developed based on Medicaid encounter data (described starting on Page 9 of 2004-2005 Per Capita Cost report).</p>

Item #	Legal Cite	Subject	Comments
AA.2.2	<p>1905(p) (1-3)</p> <p>SMM 3490 (ff)</p> <p>SMD letter 9/30/00</p>	<p><u>Dual Eligibles (DE)</u>–Some States include capitation payments for DE. Because the statute and CMS policy specifies that the State may only pay for Medicaid-eligible individuals, those Medicaid payment limits must be observed if the program includes DE. See the Attachment to Appendix A for additional information on Dual Eligibles.</p> <p>Only the following groups of DE are entitled to Medicaid Services. If they are included in a capitated managed care contract, they should have a Medicaid rate calculated separately from other DE:</p> <ul style="list-style-type: none"> <li>■ QMB Plus</li> <li>■ Medicaid (Non QMB and Non SLMB)</li> <li>■ SLMB Plus</li> </ul> <p>Eligibles and services for beneficiaries in the four non-Medicaid DE categories</p> <ul style="list-style-type: none"> <li>■ QMB-only</li> <li>■ QDWI</li> <li>■ SLMB-only</li> <li>■ QI-1</li> </ul> <p>should be specifically excluded from the capitated rates calculated for the 3 DE categories above (QMB Plus, Medicaid (Non QMB and Non-SLMB), and SLMB Plus). If DE beneficiaries in the non-Medicaid four categories are allowed to choose to enroll in capitated managed care, the Medicaid State Agency would continue to be liable for the same Medicare payments (e.g., Medicare fee-for-service premiums) as under FFS. The beneficiary would be liable for any Medicaid services payment because they are not eligible for Medicaid services:</p> <p>For QMB-only and QMB-Plus, the State may also need to calculate a separate payment to the capitated organization for Medicare cost-sharing or premium amounts. If the M+C organization charges monthly premiums,. Medicaid is liable for payment of monthly M+C premium amounts for QMB categories (QMB-only and QMB Plus) for the basic packages of Medicare covered benefits only, if so elected in the Medicaid State plan (State Plan preprint page 29, 3.2(a)(1)(i)). Medicaid is also liable for Medicare cost-sharing expenses (deductibles, coinsurance and copayments) for Medicare covered services to the payment amount specified in the Medicaid State plan (Supplement 1 to Attachment 4.19-B). When an M+C organization imposes cost-sharing charges in addition to premiums for Medicare-covered services on their enrollees, the Medicaid agency must pay those costs for QMBs regardless of whether the State elected to include premiums in cost-sharing. No Medicaid services or payments would be included in the payment calculated for the entity.</p>	<p>Capitation rates are based on encounter data, and thus reflect only those eligibility groups enrolled in plans. Eligibility groups described on Pages 4-5 of the 2004-2005 Per Capita Cost report.</p> <p>Oregon allows only Medicaid Dual Eligibles to enroll in managed care plans. The State pays the Medicare premiums directly for Dual Eligibles.</p>
AA.2.3	<p>42 CFR 435.1002(b)</p> <p>1903(f)(2)(A)</p> <p>SMM 3645</p>	<p><u>Spenddown</u> – FFP is not available for expenses that are the recipient’s liability for recipients who establish eligibility for Medicaid by deducting incurred medical expenses from income.</p> <p>Spenddown is the amount of money that an individual with income over Medicaid eligibility limits must spend on medical expenses prior to gaining Medicaid eligibility. The spenddown amount is equal to the dollar amount the individual’s income is over the Medicaid income limit. 42 CFR 435</p>	<p>Not applicable.</p>

Item #	Legal Cite	Subject	Comments
		<p>Subpart D.</p> <p>States have two methods for calculating spenddown. Regardless of the option selected by the State, the State should not request federal Medicaid match for expenses that are the recipient's liability. Typically this means that capitated rates must be calculated without including expenses that are the recipient's liability.</p> <ol style="list-style-type: none"> <li>1. Regular method – The individual client collects documentation verifying that a medical expense has occurred and submits to the State. States must ensure that capitation rates for individuals with spenddown (both medically needy beneficiaries and beneficiaries in 209(b) States with spenddown amounts) are calculated without including expenses that are the recipient's liability.</li> <li>2. Pay-in method – The individual client pays a monthly installment payment or lump sum payment to the State equal to the spenddown amount rather than collecting documentation on medical expenses and submitting that documentation to the case worker. The same income and resource standards apply as in the regular method. The State then tracks the client's medical costs to ensure that the costs exceed the spenddown amount. Here the State sets capitation rates to include expenses that are of the recipient's liability and must ensure that the federal government receives its share of the monthly or lump sum payment from the client.</li> </ol>	
AA.2.4	<p>42 CFR 438.6(c)(1)(i)(B)</p> <p>42 CFR 438.6(c)(4)(ii)(A)</p>	<p><u>State Plan Services only</u> - The State must document that the actuarially sound capitation rates are appropriate for the services to be furnished under the contract and based only upon services covered under the State Plan (or costs directly related to providing these services, for example, MCO, PIHP, or PAHP administration). <i>The explanation and documentation should list the services specifically included and excluded from the analysis.</i> Services provided by the managed care plan that exceed the services covered in the Medicaid State Plan may not be used to set capitated Medicaid managed care rates (e.g., 1915(b)(3) waiver services or services outlined in 42 CFR 438.6(e) as referenced in AA 2.5.</p> <ul style="list-style-type: none"> <li>• <i>States using entity <b>encounter data</b> may base utilization and service costs on non-FFS data adjusting the data to reflect State plan services only.</i></li> <li>• <i><b>Services not part of the State plan</b> that are unilaterally contractually required or “suggested” (typically authorized as “1915(b)(3) services”) may not be used to calculate actuarially sound rates and must be paid out of separate payment rates approved prospectively under the 1915(b) waiver process.</i></li> <li>• <i><b>EPSDT extended/supplemental services</b> for children are State Plan Approved services and may be built into the capitated rates</i></li> <li>• <i><b>1115(a)(2) services</b> are considered State Plan services for 1115 populations for the duration of the demonstration and may be built into capitated payments approved through the 1115 demonstration budget neutrality agreement for approved populations only.</i></li> <li>• <i><b>HCBS waiver services</b> may only be included for capitated contracts under 1915(b)/(c) concurrent waiver or in CMS RO approved 1915(a)(1)(A)/(c) capitated contracts for approved 1915(c) waiver participants. Note: for the purposes of pre-PACE under 1915(a)(1)(A) HCBS services should be included. If the population is a nursing home-certifiable population and</i></li> </ul>	<p>Encounter data serves as basis of the capitation rates. Adjustments are made to exclude services not covered under the Prioritized List (process described on Pages 29-36 of the 2004-2005 Per Capita Cost report).</p>

Item #	Legal Cite	Subject	Comments
		<p><i>eligible for HCBS, the State may consider HCBS as an acceptable service for long-term care managed care.</i></p> <ul style="list-style-type: none"> <li><b>1915(a)(1)(A) capitated rates</b> must be based on State Plan Approved services only and 1915(c) approved services for 1915(c) participants.</li> </ul> <p><i>Note: The inclusion of any additional Medicaid services during the term of a contract could either be handled through a contract amendment or a contract term that provides for the contingency, subject to CMS approval. Amendments must be prior approved by the CMS RO.</i></p>	
AA.2.5	438.6(e)	<p><u>Services that may be covered by a capitated entity out of contract savings</u> - An entity may provide services to enrollees that are in addition to those covered under the State plan, although the cost of these services cannot be included when determining the payment rates. <i>Note: this is different than 1915(b)(3) waiver services which are contractually required by the State. When a State agency decides to contract with an entity, it is arranging to have some or all of its State plan services provided to its Medicaid population through that entity. The State has not modified the services that are covered under its State plan, nor is it continuing to pay, on a FFS basis, for each and every service to be provided by the entity. Further, entities have the ability to provide services that are in the place of, or in addition to, the services covered under the State plan, in the most efficient manner that meets the needs of the individual enrollee. These additional or alternative services do not affect the capitation rate paid to the entity by the State. The capitation rates should not be developed on the basis of these services. The State determines the scope of State plan benefits to be covered under the managed care contract, and sets payment rates based on those services. This does not affect the entities right, however, to use these payments to provide alternative services to enrollees that would not be available under the State plan to beneficiaries not enrolled in the entity. Section 1915(b)(3) waiver authority that allows a State to share savings resulting from the use of more cost-effective medical care with beneficiaries by providing them with additional services.</i></p>	Not applicable.
AA.3.0	42 CFR 438.6(c)(3)(ii) and (iv)	<p><u>Adjustments to the Base Year Data</u> - The State made adjustments to the base period to construct rates to reflect populations and services covered during the contract period. These adjustments ensure that the rates are predictable for the covered Medicaid population.</p> <p>All regulatorily referenced adjustments are listed in 3.1 through 3.14.</p> <p><b>Adjustments must be mutually exclusive and may not be taken twice. States must document the policy assumptions, size, and effect of these adjustments and demonstrate that they are not double counting the effects of each adjustment. The RO should check to ensure that the State has contract clauses (or State Plan Amendments), where appropriate, for each adjustment.</b></p> <p>Sample Adjustments to the Base Year that may increase the Base Year:</p> <ul style="list-style-type: none"> <li>Administration (Step AA.3.2)</li> <li>Benefit, Programmatic and Policy change in FFS made after the claims data tape was cut (Step AA.3.1)</li> </ul>	Adjustments are described on pages 13-28 of the 2004-2005 Per Capita Cost report. Pages 5-9 of the FY 2004 Capitation Rate report also describe adjustments made in the development of the capitation rates.

Item #	Legal Cite	Subject	Comments
		<ul style="list-style-type: none"> <li>• Claims completion factors (Step AA.3.2)</li> <li>• Medical service cost trend inflation (Step AA.3.3)</li> <li>• Utilization due to changes in FFS utilization between the Base Year and the contract period. Changes in utilization of medical procedures over time is taken into account (Step AA.3.11)</li> <li>• Certified Match provided by public providers in FFS</li> <li>• Cost-sharing in FFS is not in the managed care program</li> <li>• FFS benefit additions occurring after the extraction of the data from the MMIS are taken into account</li> <li>• One-time only adjustment for historically low utilization in FFS program of a State Plan Approved benefit (i.e., dental)</li> <li>• Patient liability for institutional care will be charged under this program</li> <li>• Payments not processed through the MMIS</li> <li>• Price increase in FFS made after the claims data tape was cut</li> </ul> <p>Sample Adjustments to the Base Year that may adjust the Base Year downward:</p> <ul style="list-style-type: none"> <li>• Benefit deletions in the FFS Program occurring after the extraction of the data from the MMIS are taken into account (Step AA.3.1)</li> <li>• Cost-sharing in managed care in excess of FFS cost-sharing</li> <li>• Disproportionate Share Hospital Payments (Step AA.3.5)</li> <li>• Financial Experience Adjustment</li> <li>• FQHC/RHC payments</li> <li>• Graduate Medical Education (Step AA.3.8)</li> <li>• Income Investment Factor</li> <li>• Indirect Medical Education Payments (Step AA.3.8)</li> <li>• Managed Care Adjustment</li> <li>• PCCM Case Management Fee</li> <li>• Pharmacy Rebates</li> <li>• Post-pay recoveries (TPL) if the State will not collect and allow the MCE to keep TPL payments (Step AA.3.6)</li> <li>• Recoupments not processed through the MMIS</li> <li>• Retrospective Eligibility costs (Step AA.3.4)</li> </ul> <p>Cost-neutral Adjustments:</p> <ul style="list-style-type: none"> <li>• Data smoothing for data distortions and individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims including risk-sharing and reinsurance (Step AA.5.0)</li> </ul> <p><i>Note: The CMS RO must review all changes for appropriateness to the data selected by the State (e.g., if the State is using encounter data, then adjustments for FFS changes may not be appropriate). Some adjustments are mandatory. They are noted as such.</i></p>	

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		<p><i>All adjustments must be documented. Adjustments must be mutually exclusive and may not be taken twice. States must document the policy assumptions, size, and effect of these adjustments and demonstrate that they are not double counting the effects of each adjustment. The RO should check to ensure that the State has contract clauses (or State Plan Amendments), where appropriate, for each adjustment.</i></p>	
AA.3.1	<p>42 CFR 438.6(c)(1)(B)</p> <p>42 CFR 438.6(c)(4)(ii)(A)</p>	<p><u>Benefit Differences</u> - Actuarially sound capitation rates are appropriate for the services to be furnished under the contract. The State must document that actuarially sound capitation rates payments are based only upon services covered under the State Plan. <i>Differences in the service package for the Base Period data and the Medicaid managed care covered service package are adjusted in the rates. Documentation of assumptions and estimates is required for this adjustment.</i></p>	<p>Changes to benefits described on Pages 23-24 of Per Capita Cost report and Pages 6-8 of the FY 2004 Capitation Rate report.</p>
AA.3.2	<p>42 CFR 438.6(c)(4)(ii) (A)</p> <p>42 CFR 438.6(c)(3)(ii)</p> <p>42 CFR 438. 812</p> <p>Family Planning FMAP 1903(a)(5) and 42 CFR 433.10(c)(1)</p> <p>Title XIX Financial Management Review Guide #20 Family Planning Services (See page 1 of this guide for a complete list of statutory and regulatory references) 7/3/01 SMD Letter</p>	<p><u>Administrative cost allowance calculations</u> - The State must document that an adjustment was made to the rate to account for MCO, PIHP or PAHP administration. Only administrative costs directly related to the provision of Medicaid State Plan approved services to Medicaid-eligible members are built into the rates. <i>Documentation of assumptions and estimates is required.</i></p> <p>In order to receive Federal reimbursement, administrative costs at the entity level are subject to all applicable Medicaid administrative claiming regulations and policies. Medicaid pays for the administration of Medicaid services to Medicaid beneficiaries covered under the contract. The following examples are not all inclusive.</p> <ul style="list-style-type: none"> <li>• Public entities cannot build in administrative costs to pay for non-Medicaid administration or services such as education, prisons, or roads, bridges and stadiums using the administrative cost in capitated rates.</li> <li>• Administrative costs for State Plan approved services can only be claimed for services to be delivered to Medicaid beneficiaries under the contract (not for 1915(b)(3) services. Administration costs in contracts must be allocated to the appropriate programs (e.g. public health must pay for the administration of public health services to non-Medicaid eligibles). CMS provides FFP only for the administration of Medicaid services to Medicaid beneficiaries covered under the contract.</li> <li>• Regular Medicaid matching rules apply. See 42 CFR 438.812 which states that all payments under a risk contract are medical assistance costs (FMAP rate) and which requires an allocation for non-risk contracts between service costs and administrative costs. Separate administrative costs under the State Plan should not be placed under a capitated contract in order for the State to draw down the FMAP (50-80%) rate rather than the administrative rate (50%). Examples of this include: survey and certification costs or other administrative costs not associated with the plan’s provision of contractually-required covered State Plan services to Medicaid enrollees. Separate administrative contracts including this administration can be written for capitated entities that</li> </ul>	<p>Amount of administrative cost allowance documented on pages 26-27 of the 2004-2005 Per Capita Cost report and Page 9 of FY 2004 Capitation Rate report.</p>

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	Indian Health Service facility FMAP 1905(b) and 42 CFR 433.10(c)(2)	<p>will be matched at 50% by the federal government. <i>Note: Family planning and Indian health services enhanced matching FMAP rates and rules do apply to family planning and Indian Health services in capitated contracts. For family planning, the State must document the portion of its rates that are family planning consistent with the CMS Title XIX Financial Management Review Guide #20 Family Planning Services, especially Exhibit A. Please refer to the 7/3/01 SMD letter regarding the need for timely filing of claims.</i></p> <ul style="list-style-type: none"> <li>• Paperwork costs, such as time spent writing up case notes, associated with face-to-face contact with an eligible member is already included in the direct service cost and should not be built into the capitated rates again. Medicaid State agencies should also not pay separately for this administration. This occurs when an entity contracts with a public entity to provide services. The public entity provides the direct services and then bills the State Medicaid agency or the entity for administration associated with the direct services. Schools are providing the primary examples of this practice. This could also occur if an entity builds in additional administrative costs associated with direct service that have already been built into the direct service rates to providers.</li> </ul> <p><i>Note: CMS does not have established standards for risk and profit levels but does allow reasonable amounts for risk and profit to be included in capitated rates.</i></p>	
AA.3.3	42 CFR 438.6(c)(3)(ii)	<p><u>Special populations' adjustments</u> - Specific health needs adjustments are made to make the populations more comparable. The State may make this adjustment only if the population has changed since the utilization data tape was produced (e.g., the FFS population has significantly more high-cost refugees) or the base population is different than the current Medicaid population (e.g., the State is using the State employees health insurance data). The State should use adjustments such as these to develop rates for new populations (e.g., SCHIP eligibles or 1115 expansion eligibles). The State should document why they believe the rates are adequate for these particular new populations.</p>	Not applicable.
AA.3.4	42 CFR 438.6(c)(3)(ii) and (iv)	<p><u>Eligibility Adjustments</u> - The actuary analyzed the covered months in the base period to ensure that member months are parallel to the covered months for which the entities are taking risk. Adjustments are often needed to remove from the base period covered months -- and their associated claims -- that are not representative of months that would be covered by an entity. For example, many newborns are retrospectively covered by FFS Medicaid at birth, and will not enroll in an entity (even in mandatory enrollment programs) until a few months after birth. Because the costs in the first months of life are very high, if retrospective eligibility periods are not removed from the base period the state could be substantially over-estimating entities' average PMPM costs in the under-1 age cohort. Similar issues exist with the mother's costs when the delivery is retrospectively covered by FFS Medicaid, and with retrospective eligibility periods in general.</p>	Not applicable since managed care encounter and eligibility data form the basis of the capitation rates.
AA.3.5	1923(i) BBA 4721(d)	<p><u>DSH Payments [contracts signed after 7/1/97]</u> - DSH payments may not be included in capitation rates. The State must pay DSH directly to the DSH facility.</p>	Not applicable since DSH payments are not included in hospital cost reports used to

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			determine funding for hospital services.
AA.3.6	42 CFR 433 Sub D 42 CFR 447.20 SMM 2089.7	<u>Third Party Liability (TPL)</u> – The contract must specify any activities the entity must perform related to third party liability. The Documentation must address third party liability payments and whether the State or the entity will retain TPL collections. Rates must reflect the appropriate adjustment (i.e., if the entity retains TPL collections the rates should be adjusted downward or if the State collects and retains the TPL the rates should include TPL).	Addressed in Appendix Exhibit A-3 of the FY 2004 Capitation Rate report.
AA.3.7	42 CFR 447.58  SMM 2089.8	<u>Copayments, Coinsurance and Deductibles in capitated rates</u> –If the State uses FFS as the base data to set rates and the State Medicaid agency chooses not to impose the FFS cost-sharing in its pre-paid capitation contracts with entities, the State must calculate the capitated payments to the organization as if those cost sharing charges were collected. For example, if the State has a \$2 copayment on FFS beneficiaries for each pharmacy prescription, but does not impose this copayment on any managed care member, the State must add back an amount to the capitated rates that would account for the lack of copayment. <i>Note: this would result in an addition to the capitated rates.</i>  For 1115 expansion beneficiaries only, if the state uses FFS as the base data to set rates and imposes more deductibles, coinsurance, co-payments or similar charges on capitated members than the State imposes on its fee-for-service beneficiaries, the State must calculate the rates by reducing the capitation payments by the amount of the additional charges. <i>Note: this would result in a reduction to the capitated rates.</i>	Not applicable. Encounter data is used as the basis of the capitation rates.
AA.3.8	42 CFR 438.60  42 CFR 438.6(c)(5)(v)	<u>Graduate Medical Education (GME)</u> - If a State makes GME payments directly to providers, the capitation payments should be adjusted to account for the aggregate amount of GME payments to be made on behalf of enrollees under the contract (i.e., the State should not pay the entity for any GME payments made directly to providers). States must first establish actuarially sound capitation rates prior to making adjustments for GME.  CMS permits such payments only to the extent the capitation rate has been adjusted to reflect the amount of the GME payment made directly to the hospital. States making payments to providers for GME costs under an approved State plan must adjust the actuarially sound capitation rates to account for the aggregate amount of GME payments to be made directly to hospitals on behalf of enrollees covered under the contract. These amounts cannot exceed the aggregate amount that would have been paid under the approved State plan for FFS. This prevents harm to teaching hospitals and ensures the fiscal accountability of these payments.	Addressed in Appendix Exhibit A-3 of the FY 2004 Capitation Rate report.
AA.3.9	1903(m)(2)(A)(ix) 1902(bb)	<u>FQHC and RHC reimbursement</u> – The State may build in only the FFS rate schedule or an actuarially equivalent rate for services rendered by FQHCs and RHCs. The State may NOT include the FQHC/RHC encounter rate, cost-settlement, or prospective payment amounts. The entity must pay FQHCs and RHCs no less than it pays non-FQHC and RHCs for similar services. In the absence of a specific 1115 waiver, the entity cannot pay the annual cost-settlement or prospective payment.	Addressed in Appendix Exhibit A-3 of the FY 2004 Capitation Rate report.
AA.3.10	42 CFR	<u>Medical Cost/Trend Inflation</u> – Medical cost and utilization trend inflation factors are based on	Trend adjustments

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	438.6(c)(3)(ii)	<p>historical medical State-specific costs or a national/regional medical market basket applicable to the state and population. All trend factors and assumptions are explained and documented.</p> <p><i>Note: This also includes price increases not accounted for in inflation (i.e., price increases in the fee-for-service or managed care programs made after the claims data tape was cut). This adjustment is made if price increases are legislated by the Legislature. The RO must ensure that the State “inflates” the rate only once and does not double count inflation and legislative price increases. The State must document that program price increases since the rates were originally set are appropriately made.</i></p>	described on Pages 25-26 of 2004-2005 Per Capita Cost report and Page 5 of the FY 2004 Capitation Rate report.
AA.3.11	42 CFR 438.6(c)(3)(ii) and (iv)	<p><u>Utilization Adjustments</u> - Generally, there are two types of Utilization adjustments are possible: utilization differences between base data and the Medicaid managed care population and changes in Medical utilization over time.</p> <ul style="list-style-type: none"> <li>• Base period differences between the underlying utilization of Medicaid FFS data and Medicaid managed care data assumptions are determined. These adjustments increase or decrease utilization to levels that have not been achieved in the base data, but are realistically attainable CMS program goals. States may pay for the amount, duration and scope of State plan services that States expect to be delivered under a managed care contract. Thus, States may adjust the capitation rate to cover services such as EPSDT or prenatal care at the rate the State wants the service to be delivered to the enrolled population. The RO should check to ensure that the State has a contract clause for using mechanisms such as financial penalties if service delivery targets are not met or incentives for when targets are met. <i>Note: an example of this adjustment is an adjustment to Medicaid FFS data for EPSDT where FFS beneficiaries have historically low EPSDT utilization rates and the managed care contract requires the entity to have a higher utilization rate. The State should have a mechanism to measure that the higher utilization occurs and the RO should verify that this measurement occurs.</i></li> <li>• A change in utilization of medical procedures over time is taken into account. Documentation is required if this adjustment is made. The State should document 1) The assumptions made for the change in utilization. 2) How it came to the precise adjustment size. 3) That the adjustment is a unique change that could not be reflected in the utilization database because it occurred after the base year utilization data tape was cut. Examples may include: major technological advances (e.g., new high cost services) that cannot be predicted in base year data (protease inhibitors would be acceptable, a new type of aspirin would not be acceptable).</li> </ul> <p><i>Note: These adjustments can be distinguished from each other. The first is utilization change stemming from historic under- or over-utilization that is being corrected solely by the implementation of this program. Historic access problems in FFS Medicaid programs may be addressed through this adjustment. The second is a one time only non-recurring adjustment because of a unique utilization change projected to occur (or which did occur) after the base year data tape was</i></p>	<p>The first adjustment is not applicable since encounter data is the basis of the capitation rates.</p> <p>The second adjustment is included in the utilization trend, which is described on Pages 25-26 of the 2004-2005 Per Capita Cost Report and Page 5 of the FY 2004 Capitation Rate report.</p>

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AA.3.12	42 CFR 438.6(c)(4)(ii)  42 CFR 438.6(c)(3)(iv)  42 CFR 438.6(c)(1)(i)(B)	<p><i>produced.</i></p> <p><u>Utilization and Cost Assumptions</u> – The State must document that the utilization and cost data assumptions for a voluntary program were analyzed and adjusted to ensure that they are appropriate for the populations to be covered if a healthier or sicker population voluntarily chooses to enroll (compared to the population data on which the rates are set). The State must document that utilization and cost assumptions that are appropriate for individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims, using risk adjustment, risk-sharing or other appropriate cost-neutral methods</p> <p><i>Note: this analysis is needed whenever the population enrolled in the managed care program is different than the data for which the rates were set (e.g., beneficiaries have a choice between a fee-for-service program (PCCM) and a capitated program (MCO) and the rates are set using FFS data) .</i></p>	Not applicable.
AA.3.13	42 CFR 435.725 (Categorically Needy)  42 CFR 435.832 (Medically Needy)	<p><u>Post-Eligibility Treatment of Income (PETI)</u> <i>(This applies for NF, HCBS, ICF-MR, and PACE beneficiaries in capitated programs where PETI applies only.)</i> If the State Plan or waiver requires that the State consider post-eligibility treatment of income for institutionalized beneficiaries, the actual rate paid to the capitated entity would be the rate for the member minus any patient liability for that specific enrolled member. The State should calculate the client participation amount specifically for each member using the FFS methodology.</p> <p><i>Patient liability is a post-eligibility determination of the amount an institutionalized Medicaid beneficiary is liable for the cost of their care. It is also called client participation, cost of care, PE, and post-eligibility treatment of income. 42 CFR 435 Subpart H. Client participation should not be used to reduce total costs for all participants. Client participation should be assessed individually, reducing the individual rate paid to the capitated entity, not computed in aggregate and reducing all capitation payments. If the MMIS data tape is cut to reflect only the amount the Medicaid agency paid providers, then patient liability for cost of care must be added back to the rate to determine the total cost of care for an individual. The actual rate paid to the capitated entity would be the rate for the member minus any patient liability for that specific enrolled member. The capitated entity would then need to collect the patient liability from the enrolled member.</i></p> <p>An Option under 42 CFR 435.725(f) - The State can use a projection of expenses for a prospective period not to exceed 6 months to calculate client participation. This option requires the State to reconcile estimates with incurred expenses. Even with this option, the State must reduce the capitation rate to exclude expenses that are of the recipient’s liability. This procedure ensures that the federal government does not pay more than its share of costs.</p>	Not applicable.
AA.3.14	42 CFR 438.6(c)(3)(ii)	<p><u>Incomplete Data Adjustment</u>– The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the Actuary must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including “lag factors,” “incurred but not reported (IBNR) factors,” or incurring factors. If date of payment (DOP) data is</p>	Described on page 20 of the 2004-2005 Per Capita Cost report.

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		used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods. <i>Documentation of assumptions and estimates is required for this adjustment.</i>	
AA.4.0	42 CFR 438.6(c)(3)(iii)  FR 6/14/02 p41001	<u>Establish Rate Category Groupings (All portions of subsection AA.4 are mandatory)</u> -- The State has created rate cells specific to the enrolled population. <i>The rate category groupings were made to construct rates more predictable for future Medicaid populations' rate setting. The number of categories should relate to the contracting method. Rate cells need to be grouped together based upon predictability so entities do not have incentives to market and to enroll one group over another. Multiple rate cells should be used whenever the average costs of a group of beneficiaries greatly differ from another group and that group can be easily identified. Note: The State must document that similar cost categories are grouped together to improve predictability. For example, rate cells may be combined if there is an insufficient number of enrollees in any one category to have statistical validity.</i>	A combination of eligibility category and age groupings are used to determine rate categories as described on Pages 4-5 of the 2004-2005 Per Capita Cost report and Pages 3-4 of the FY 2004 Capitation Rate report.
AA.4.1	42 CFR 438.6(c)(3)(iii)(B)	<u>Age</u> - Age Categories are defined. If not, justification for the predictability of the methodology used is given.	Age categories are defined and used for the Children rate categories. For certain other rate categories, distinctions between recipients with and without Medicare coverage was used a determinant of cost predictability. CDPS risk adjustment contains an age-based component, which adjusts for differences in risk among different age cohorts.
AA.4.2	42 CFR 438.6(c)(3)(iii)(C)	<u>Gender</u> -Gender Categories are defined. If not, justification for the predictability of the methodology used is given	Gender was not used as a rate category. With the implementation of a

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			maternity case rate and the related carve-out of maternity services from the capitation rates, a significant source of cost variation between genders has been eliminated.
AA.4.3	42 CFR 438.6(c)(3)(iii)(D)	<u>Locality/Region</u> - Locality/region Categories are defined. If not, justification for the predictability of the methodology used is given	Regions are described on Page 4 of the FY 2004 Capitation Rate report and the regional adjustment on Pages 5-13. The regions are defined based on the general service delivery areas of the plans.
AA.4.4	42 CFR 438.6(c)(3)(iii)(E)	<u>Eligibility Categories</u> - Eligibility Categories are defined. If not, justification for the predictability of the methodology used is given.	Eligibility categories defined on Pages 4-5 of the 2004-2005 Per Capita Cost report and Pages 3-4 of the FY 2004 Capitation Rate report.
AA.5.0	42 CFR 438.6(c)(3)(ii), (iii) and (iv)  42 CFR 438.6(c)(1)(ii)	<u>Data Smoothing (All portions of subsection AA.5 are mandatory)</u> - The State has examined the data for any distortions and adjusted in a cost-neutral manner for distortions and special populations. Distortions are primarily the result of small populations, special needs individuals, access problems in certain areas of the State, or extremely high-cost catastrophic claims. Costs in rate cells are adjusted through a cost-neutral process to reduce distortions across cells to compensate for distortions in costs, utilization, or the number of eligibles. This process adjusts rates toward the statewide average rate. The State must supply an explanation of the smoothing adjustment, an understanding of what was being accomplished by the adjustment, and demonstrate that, in total, the aggregate dollars accounted	Addressed in Appendix Exhibit A-3 of the FY 2004 Capitation Rate report.

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		<p>for among all the geographic areas after smoothing is basically the same as before the smoothing.</p> <p>The State has taken into account individuals with special health care needs and catastrophic claims. These populations should only be included if they are an eligible, covered population under the contract. Claim costs and utilization for high cost individuals (e. g., special needs children) in the managed care program are included in the rates.</p>	
AA.5.1	42 CFR 438.6(c)(3)(iv)	<p><u>Special Populations and Assessment of the Data for Distortions</u> – Because the rates are based on actual utilization in a population, the State must assess the degree to which a small number of catastrophic claims might be distorting the per capita costs. Other payment mechanisms and utilization and cost assumptions that are appropriate for individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims, using risk adjustment, risk-sharing, or other appropriate cost-neutral methods may be necessary.</p> <p>If no distortions or outliers are detected by the actuary, a rate setting method that uses utilization and cost data for populations that include individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims will meet requirements for special populations without additional adjustments, since the higher costs would be reflected in the enrollees’ utilization. States must document their examination of the data for outliers and smooth appropriately.</p> <p>The fact that the costs of these individuals are included in the aggregate data used for setting rates will not account for the costs to be incurred by a contractor that, due to adverse selection or other reasons, enrolls a disproportionately high number of these persons. CMS requires some mechanism to address this issue. Most entity contracts currently use either stop-loss, risk corridors, reinsurance, health status-based risk adjusters, or some combination of these cost-neutral approaches.</p> <p><i>Note: The RO should verify that this assessment occurred and that distortions found were addressed in 5.2.</i></p>	Addressed in Appendix Exhibit A-3 of the FY 2004 Capitation Rate report.
AA.5.2	42 CFR 438.6(c)(1)(iii)  42 CFR 438.6(c)(3)(ii) and (iv)  SMM 2089.6	<p><u>Cost-neutral data smoothing adjustment</u> -- If the State determines that a small number of catastrophic claims are distorting the per capita costs then at least one of the following cost-neutral data smoothing techniques <b>must</b> be made.</p> <p>Cost neutral means that the mechanism used to smooth data, share risk, or adjust for risk will recognize both higher and lower expected costs and is not intended to create a net aggregate gain or loss across all payments.</p> <p>Actuarially sound risk sharing methodologies will be cost neutral in that they will not merely add additional payments to the contractors’ rates, but will have a negative impact on other rates, through offsets or reductions in capitation rates, so that there is no net aggregate assumed impact across all payments. A risk corridor model where the State and contractor share equal percentages of profits and losses beyond a threshold amount would be cost neutral.</p>	Addressed in Appendix Exhibit A-3 of the FY 2004 Capitation Rate report.

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		<p>The mechanism should be cost neutral in the aggregate. How that is determined, however, will differ based on the type of mechanism that is used. A stop-loss mechanism will require an offset to capitation rates under the contract, based on the amount and type of the stop-loss. Health status-based risk adjustment may require an adjustment to the capitation rate for all individuals categorized through the risk adjustment system, but the aggregate program impact will still be neutral. CMS will recognize that any of these mechanisms may result in actual payments that are not cost neutral, in that there could be changes in the case mix or relative health status of the enrolled population. As long as the risk sharing or risk adjustment system is designed to be cost neutral, it would meet this requirement regardless of unforeseen outcomes such as these resulting in higher actual payments.</p> <p>Data Smoothing Techniques:</p> <ul style="list-style-type: none"> <li>___ Provision of stop loss, reinsurance, or risk-sharing (See 6.0)</li> <li>___ Catastrophic Claims Adjustment – The State must identify that there are outlier cases and explain how the costs associated with those outlier cases were separated from the rate cells and then redistributed across capitation payment cells in a cost-neutral, yet predictive manner.</li> <li>___ Small population or small rate cell adjustment – The State has used one of three methods: 1) The actuary has collapsed rate cells together because they are so small, 2) the actuary has calculated a statewide per member per month for each individual cell and multiplied regional cost factors to that statewide PMPM in a cost-neutral manner, or 3) the actuary bases rates on multiple years data for the affected population weighted so that the total costs do not exceed 100% of costs (e.g., 3 years data with most recent year’s data weighted at 50%, 2<sup>nd</sup> most recent year’s data weighted at 30% and least recent year weighted at 20%).</li> <li>___ Mathematical smoothing – The actuary develops a mathematical formula looking at claims over a historical period (e.g., 3 to 5 years) that identifies outlier cost averages and corrects for skewed distributions in claims history. The smoothing should account for cost averages that are higher and lower than normal in order to maintain cost-neutrality.</li> <li>___ Maternity Kick-Payment (Per delivery rate) – Non-delivery related claims were separated from delivery related claims. The non-delivery related claims were sorted into categories of service and used to base the managed care capitation payments. Delivery-related costs were removed from the total final paid claims calculations. The State developed a tabulation of per-delivery costs only. The State reviewed the data for accuracy and variance. The State develops a single, average, per-delivery maternity rate across all cohorts and across all regions unless variance warrants region-specific per-delivery maternity rates. Some states also have birth kick payments to cover costs for a newborn’s birth (Per newborn rate).</li> <li>___ Applying other cost-neutral actuarial techniques to reduce variability of rates and improve average predictability. If the State chooses to use a method other than the catastrophic claims adjustment or a small population or small rate cell adjustment, the State explains the methodology. The actuary assisted with the development of the methodology, the approach is reasonable, the methodology was discussed with the State, and an explanation and</li> </ul>	

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		documentation is provided to CMS.	
AA.5.3	42 CFR 438.6(c)(1)(iii)  42 CFR 438.6(c)(3)(iii) and (iv)	<p>Risk-Adjustment – The State may employ a risk adjustment methodology based upon enrollees’ health status or diagnosis to set its capitated rates. If the State uses a statistical methodology to calculate diagnosis-based risk adjusters they should use generally accepted diagnosis groupers. The RO should verify that:</p> <ul style="list-style-type: none"> <li>• The State explains the risk assessment methodology chosen</li> <li>• Documents how payments will be adjusted to reflect the expected costs of the disabled population</li> <li>• Demonstrates how the particular methodology used is cost-neutral</li> <li>• Outlines periodic monitoring and/or rebasing to ensure that the overall payment rates do not artificially increase, due to providers finding more creative ways to classify individuals with more severe diagnoses (also called upcoding or diagnosis creep).</li> </ul> <p>Risk-adjustment must be cost-neutral. <i>Note: for example, risk-adjustment cannot add costs to the managed care program. Risk adjustment can only distribute costs differently amongst contracting entities.</i></p>	The risk adjustment procedure is described on Pages 13-16 of the FY 2004 Capitation Rate report.
AA.6.0	42 CFR 438.6(c)(4)(iv)  42 CFR 438.6(c)(5)(i)  42 CFR 438.6(c)(2)(ii)	<p><u>Stop Loss, Reinsurance, or Risk-sharing arrangements (8.0 is mandatory if the State chooses to offer one of these options) (State Optional Policy)</u> – The State must submit an explanation of state’s reinsurance, stop loss, or other risk-sharing methodologies. These methodologies must be computed on an actuarially sound basis. <i>Note: If the State utilizes any of the three risk-sharing arrangements, please mark the applicable method in 8.1, 8.2, or 8.3. For most contracts, the three options are mutually exclusive and a State will use only one technique per contract. If a State or contract uses a combination of methodologies in a single contract, the State must document that the stop loss and risk-sharing do not cover the same services simultaneously. Plans are welcome to purchase reinsurance in addition to State-provided stop loss or risk-sharing, but CMS will not reimburse for any duplicative cost from such additional coverage.</i></p> <p>The contract must specify any risk-sharing mechanisms, and the actuarial basis for computation of those mechanisms. <i>Note: In order for the mechanism to be approved in the contract, the State or its actuary will need to provide enough information for the reviewer to understand both the operation and the financing of the risk sharing mechanism.</i></p> <p>Capitation rates are based upon the probability of a population costing a certain rate. Even if the entity’s premium rates are sufficient to cover the probable average costs for the population to be served, the entity is always at risk for the improbable – two neonatal intensive care patients and one trauma victim in its first 100 members, or an extraordinarily high rate of deliveries. A new entity, with a small enrollment to spread the risk across, could be destroyed by one or two adverse occurrences if it were obliged to accept the full liability.</p>	Not applicable

Item #	Legal Cite	Subject	Comments
		FFP is not available to fund stop loss and risk-sharing arrangements on the provision of non-State Plan services.	
AA.6.1	42 CFR 438.6(c)(4)(iv)  42 CFR 438.6(c)(5)(i)	<u>Commercial Reinsurance</u> – The State requires entities to purchase commercial reinsurance. The State should demonstrate that the contractor has ensured that the coverage is adequate for the size and age of the entity.	See Contract, Section U and Exhibit A, for financial solvency requirements.
AA.6.2	42 CFR 438.6(c)(4)(iv)  42 CFR 438.6(c)(5)(i)  SMM 2089.6	<p><u>Simple stop loss program</u> -- The State will provide stop-loss protection by writing into the contract limits on the entity’s liability for costs incurred by an individual enrollee over the course of a year (either total costs or for a specific service such as inpatient care). Costs beyond the limits are either entirely or partially assumed by the State. The entity’s capitation rates are reduced to reflect the fact that the State is assuming a portion of the risk for enrollees.</p> <ul style="list-style-type: none"> <li>■ The State has included in its documentation to CMS the expected cost to the State of assuming the risk for the high cost individuals at the chosen stop-loss limit (also called stop-loss attachment point).</li> <li>■ An explanation of the State’s stop loss program includes the amount/percent of risk for which the State versus entity will be liable.</li> <li>■ The State has explained liability for payment. In some contracts, the entity is liable up to a specified limit and partially liable for costs between that limit and some higher number. The State is wholly liable for charges above the higher limit. If there is shared risk rather than either the State or the entity entirely assuming the risk at a certain point, the entity and State determine whether the services will be reimbursed at Medicaid rates, at the entities’ rates, or on some other basis. The State must specify which provider rates will be used to establish the total costs incurred so that the entity clearly knows whether the reinsurance will pay (i.e., the attachment point is reached).</li> <li>■ The State has deducted a withhold equal to the actuarially expected cost to the State of assuming the risk for high cost individuals. The State pays out money based on actual claims that exceed the stop loss limit (i.e., above the attachment point).</li> <li>■ The State has documented whether premiums will be developed by rate cell or on a more aggregated basis.</li> </ul>	Not applicable
AA.6.3	42 CFR 438.6(c)(4)(iv)  42 CFR 438.6(c)(5)(i) and (ii)  42 CFR	<p><u>Risk corridor program</u> – Risk corridor means a risk sharing mechanism in which States and entities share in both profits and losses under the contract, outside of a predetermined threshold amount, so that after an initial corridor in which the entity is responsible for all losses or retains all profits, the State contributes a portion toward any additional losses, and receives a portion of any additional profits.</p> <p>If risk corridor arrangements result in payments that exceed the approved capitation rates, these excess payments will not be considered actuarially sound to the extent that they result in total</p>	Not applicable

Item #	Legal Cite	Subject	Comments
	438.6(c)(1)(v)	<p>payments that exceed the amount Medicaid would have paid, on a fee-for-service basis, for the State plan services actually furnished to enrolled individuals, plus an amount for entity administrative costs directly related to the provision of these services.</p> <p>The State agrees to share in both the aggregate profits and losses of an entity and protect the entity from aggregate medical costs in excess of some predetermined amount. To the extent that FFP is involved, CMS will also share in the profits and losses of the entity.</p> <p>In this instance, the State and CMS must first agree upon the benchmark point up to which federal match will be provided. Federal matching is available up to the cost of providing the same services under a non-risk contract (i.e., the services reimbursed on a Medicaid fee-for-service basis plus an amount for entity administrative costs related to the provision of those services). See 447.362. States typically require entities to adopt the Medicare cost-based entity principles for the purposes of calculating administrative costs under this model.</p> <p><i>Note: For this example, let's say the payment is \$100 and there are 10 members expected to enroll. The total capitated payment CMS will match is \$1,000.</i></p> <ul style="list-style-type: none"> <li>- <i>The State and the entity must then agree on the amount of risk to be shared between them (e.g., 5% or the risk corridor is between \$950 and \$1,050).</i></li> <li>- <i>The entity must calculate its overall costs at the end of the year and submit them to the State.</i></li> <li>- <i>Scenario 1, the entity costs are \$950: In this example, the entity's profits are within the risk corridor of \$950 to \$1,050, so the entity keeps the entire amount of capitated payments and no adjustment is made.</i></li> <li>- <i>Scenario 2, the entity costs are \$1,050: In this example, the entity's loss is within the risk corridor, so the entity keeps the entire amount of the capitated payment and no adjustment is made.</i></li> <li>- <i>Scenario 3, the entity costs are \$850: In this example, the entity profit is outside of the risk corridor, so the entity must pay the State the amount of the excess profit or \$100.</i></li> <li>- <i>Scenario 4, the entity costs are \$1,150: In this example, the entity loss is outside of the risk corridor, so the State must pay the entity the amount of the excess loss or \$100.</i></li> </ul> <p><i>Please note: FFP is not available for amounts in this contract over the fee-for-service cost of providing these services. In order to compute the fee-for-service cost of providing services, the State must "price" the capitated entity's encounter data through the State's fee-for-service MMIS system. Amounts exceeding the cost of providing these services through a non-risk contract are not considered actuarially sound. The State must "price" the encounter data for entities with open ended risk-corridors (meaning there is no limit to the State's liability) when the entity exceeds the aggregate of actuarially sound rates x member months by more than 25%. In practice the RO may require the</i></p>	

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		<p><i>“pricing” of encounter data whenever evidence suggests that the non-risk threshold has been exceeded. Similarly, the State can require documentation if evidence suggests that the entity should be profit sharing below the threshold. In this example, if the fee-for-service and entity administrative cost of providing these services were \$1,100, then FFP would only be available up to \$1,100. See 42 CFR 447.362 or Step AA.1.8 of this checklist.</i></p>	
AA.7.0	<p>42 CFR 438.6(c)(4)(iv)</p> <p>42 CFR 438.6(c)(5)(iii) and (iv)</p> <p>SMM 2089.3</p> <p>42 CFR 438.6(c)(2)(i)</p> <p>42 CFR 438.6(c)(1)(iv)</p> <p>42 CFR 438.6(c)(4)(ii)</p>	<p><b>Incentive Arrangements (9.0 is mandatory if the State chooses to implement an incentive) (State Optional Policy)</b> – Incentive arrangement means any payment mechanism under which an entity may receive additional funds over and above the capitation rates it was paid for meeting targets specified in the contract. The State must include an explanation of the State’s incentive program. Payments in contracts with incentives may not exceed 105% of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement, since such payments will not be considered actuarially sound.</p> <p>The State must document that any payments under the contract are actuarially sound, are appropriate for the populations covered and services to be furnished under the contract, and based only upon services covered under the State Plan to Medicaid-eligible individuals (or costs directly related to providing these services, for example, MCO, PIHP, or PAHP administration).</p> <ul style="list-style-type: none"> <li>• All incentives must utilize an actuarially sound methodology and based upon the provision of approved services to Medicaid eligible beneficiaries.</li> <li>• Incentives cannot be renewed automatically and must be for a fixed time period.</li> <li>• The incentive cannot be conditioned upon intergovernmental transfer agreements.</li> <li>• Incentives must be available to both public and private contractors.</li> </ul> <p><i>Note: Reinsurance collections from reinsurance purchased from a private vendor (See 8.1) and State provided stoploss (8.2) are actuarially calculated to be cost-neutral and should not considered to be “incentives” or included in these payments.</i></p>	Not applicable

**Oregon Health Plan Medicaid Demonstration  
 FY 2004 Capitation Rate Development  
 CMS Medicaid Managed Care Rate Setting Checklist – Crosswalk**

- **AA.1.8 – Limit on payment to other providers** – Payments to providers for services related to managed care contracted services are limited to the amounts paid by managed care plans, with two exceptions: 1) Cost settlements for Type A and Type B hospitals are made by OMAP; and 2) Cost settlements to Federally Qualified Health Centers and Rural Health Centers are made by OMAP. Managed care plan capitation rates are developed to allow for average payments to these providers, consistent either with their estimated cost (for Type A & B hospitals) or the community average payment rate (for FQHCs and RHCs). For these services, managed care plans are provided sufficient capitation revenue to cover the interim payments that are required by law or regulation, and OMAP takes all responsibility for the final cost settlement. If payments to a provider exceed costs, the overpayment is rebated to OMAP.

Type A and Type B cost settlements are made by OMAP with consideration for the amounts already paid by managed care plans. Managed care capitation rates related to Type A and Type B hospital payments are developed to permit payment of full costs for these hospitals. However, if hospitals costs differ from the estimated amount built into the rates, a settlement is made. The methodology for developing the payment amounts is described in the Capitation Rate report.

Other direct payments to providers, such as Graduate Medical Education, are made only for the portion of the population that is covered on a Fee-For-Service basis. Disproportionate Share Hospital payments are also made, and are based on the provision of services to individuals who are uninsured. Health plan utilization of hospitals does not affect the calculation of DSH payment amounts.

- **AA.2.0 – Methods used to exclude invalid data** – A brief description of the process for identifying invalid data is provided in the Per Capita Cost report, pages 9 – 11.

Data from all managed care plans is summarized by eligibility category and service type. Reports are generated that allow for comparison of utilization rates and costs per person per month for each combination of data and are provided to managed care plans for comparison and validation. Managed care plans are specifically asked to confirm that the total billed charges are consistent with their internal reports. Data from plans that are unable to confirm the validity of the information is excluded from the per capita cost calculation. Plans typically attempt to match expenditures to the generated reports by major service category and eligibility type, and significant effort is expended to respond to questions regarding non-matching data.

Managed care plan encounter data is submitted at regular intervals to OMAP. Prior to the data reaching PwC, OMAP staff screen the data to ensure OHP enrollment on the date of the claim. In addition, OMAP staff screen the data for missing data elements and for duplicate claims. PwC repeats these steps to confirm duplicates have been removed and that all encounter records relate to individuals enrolled with the managed care plan and the OHP on the date the service was provided.

For these calculations, data for 100% of OHP enrollees contributed to the per capita cost development for medical and dental services. For mental health services, data for nearly 93% of enrollees were included. In some cases, data for certain plans is restricted to specific service categories. The decision regarding which data are valid is made on a case-by-case basis.

- **AA.3.6. – Third Party Liability** – The State allows managed care plans to collect Third Party Liability, and includes documentation of the collected amounts on quarterly financial reports. Collection of TPL is at the managed care plan’s discretion, and the plan retains any amount it collects. Except for Medicare payments, collections for TPL are extraordinarily low in the OHP managed care plans, with total annual collections well below 1% of total health care costs.
- **AA.3.8. – Graduate Medical Education** – GME payments are made in two forms. For services covered on a fee-for-service basis, additional payments are made per discharge to teaching hospitals to cover medical education costs. For services covered through managed care plans, the health plans are paid a capitation rate that is calculated to cover average hospital costs, including education expense. Managed care plans and hospitals negotiate specific payment amounts; the state does not enter into these negotiations.
- **AA.3.9. - FQHC & RHC reimbursement** – Services provided through FQHCs and RHCs are valued in the same manner as services provided by any other comparable provider. Specifically, each service is described based on HCPCS code, which may reference the Current Procedural Terminology (CPT), American Dental Association (ADA), or other coding scheme. OMAP performs a cost settlement with each FQHC or RHC considering total costs and payments made by managed care plans. Managed care plans are required to pay FQHCs a rate that is equivalent to that paid to other community providers for comparable services.
- **AA.3.10 – Cost trending/inflation** – Trend rates were derived from a combination of information on expected changes in health care costs developed by the Centers for Medicare and Medicaid Services Office of the Actuary, combined with PwC experience with Medicaid managed care plans. The trend rates were selected to recognize expected changes in the costs per unit of service based on health policy

research, changes in costs in commercial health plans, and typical changes in payment rates. Among the considerations in assessing the cost component of trend were changes under consideration for Fee-for-Service unit costs.

Unit cost trend was derived largely from various CMS cost indices, a well respected indicator of underlying cost trend. Prescription drug cost trend was derived from recent industry reports that describe in detail the factors affecting changes in costs and utilization of those services.

- **AA.3.14 – Financial Experience Adjustment** – No adjustment is made for the financial experience of managed care plans. However, average managed care plan loss ratios are considered in determining appropriate trend rates. OMAP collects financial experience data from managed care plans on a quarterly basis. This information is used to assess whether managed care plan expenditures are within expected ranges and to determine whether trend rates chosen in prior years were reasonable. To the extent managed care plan expenditures vary significantly from prior projections, trend rates may be reconsidered in the per capita cost development process.
- **AA.5.0 - AA.5.2 – Data Smoothing** – Data smoothing issues are largely addressed by ensuring the rate cells used to develop the per capita costs have sufficient population size. No data smoothing was required for this per capita cost calculation.

Various risk adjustment factors are applied to the statewide per capita costs to derive capitation rates. These adjustments are described in the capitation report. For these calculations, the adjustment factors are explicitly calculated to be budget neutral on the date of the calculation. (Note that when adjustment factors are used to determine payment rates, final budget neutrality cannot be ensured because enrollment patterns throughout the year are unknown. Inevitably, there is some shift in enrollment mix between the time the rates are developed and the end of the contract period.)

- **AA.7.0 / AA.10.1 – Projection of Expenditures** – Per capita expenditures are calculated and compared in Exhibits 3e, 4c, 5, and 6 of the capitation rate report. The weighted average rate of change calculation uses the most recent population distribution information available at the time the calculation is made.