
**OREGON HEALTH PLAN
MEDICAID DEMONSTRATION**

**Analysis of Federal Fiscal Years 2004 – 2005
Average Costs**

November 11, 2002



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

Dear Maureen:

Re: Per Capita Costs for Federal Fiscal Years 2004 & 2005

At your request we have prepared this Analysis of Federal Fiscal Year 2004 & 2005 Average Costs for the Oregon Health Plan: Medicaid Demonstration.

This report describes our analysis and approach in detail. Please call Sandi Hunt at 415/498-5365 if you have any questions regarding the contents of this report.

Very Truly Yours,

PricewaterhouseCoopers L.L.P.

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Oregon Health Plan Medicaid Demonstration Analysis of Federal Fiscal Year 2004 & 2005 Average Costs

Executive Summary

The following report provides a calculation of the expected per capita costs for providing medical services under the Oregon Health Plan Medicaid Demonstration (OHP) for the period October 2003 through September 2005. These methods were designed to comply with the requirements of Oregon Senate Bill 27 (1989 legislature), which extended Medicaid coverage to nearly all Oregonians with incomes below the federal poverty level and stipulated guidelines for determining Medicaid provider reimbursement amounts.

The Oregon Health Services Commission has developed a “Prioritized List” of health care services, and that list is used in developing the per capita cost estimates reported here. Under the 1989 legislation the OHP did not apply to Mental Health and Chemical Dependency services and excluded individuals covered by the Aid to Blind, Aid to Disabled, Old Age Assistance, and Foster Care programs. Separate legislation added these “exempt” population groups to the OHP, effective January 1, 1995. Chemical dependency services were added to the Oregon Health Plan at the same time. In addition, a phase-in of mental health services was begun on a pilot basis for 25% of the OHP population in January 1995. Those services were expanded statewide in 1997. Children covered by the Children’s Health Insurance Program (Title

XXI) were added to the Oregon Health Plan in July 1998. Most recently, Citizen-Alien Waived Emergency Medical (CAWEM) eligibles have been explicitly identified and issued medical identification cards to use in accessing the emergency services for which they are eligible.

The services covered and the configuration of the Prioritized List have changed over time (see table below). The claims data available for this analysis reflects claims based on coverage through line 566. Should funding become available to expand coverage beyond the level of coverage available during the data period, additional data sources and analysis will be required to calculate the added coverage costs. The per capita costs shown in this report reflect costs through Line 557 of the Prioritized List as configured for the 2003-2005 biennium. The reconfiguration for the 2003-2005 biennium includes a reduction in benefits.

Effective Dates	Coverage Through Line	Reason for Change
2/1/94 – 12/31/94	565	
1/1/95 – 12/31/95	606	Mental Health lines added to list (no change in physical health benefits)
1/1/96 – 1/31/97	581	Benefits reduced
2/1/97 – 4/30/98	578	Benefits reduced
5/1/98 – 9/30/01	574	List reconfigured (no reduction in benefits)
10/1/01 – present	566	List reconfigured (no reduction in benefits)

In developing the per capita costs shown in this report, a variety of assumptions have been used, including assumptions relating to the following:

- the relationship between average billed charge amounts and the “cost” of providing services;

- the distribution of the population among the different groups of people who will be participating in the program;
- enrollment in capitated plans; and
- payment policy under the demonstration project.

Table 1 shows the average expected per capita cost by eligibility category for physical health services and chemical dependency services only and for all services. A per capita cost for the entire program is also shown.

Table 1
Per Capita Cost through Line 557 of the Prioritized List

Eligibility Category	Physical Health Services^a	All Services^b
Temporary Assistance to Needy Families	\$387.54	\$410.33
General Assistance	\$1,139.55	\$1,318.59
PLM Adults	\$862.91	\$868.47
PLM, TANF, and CHIP Children 0 < 1	\$448.98	\$449.58
PLM, TANF, and CHIP Children 1 - 5	\$89.37	\$93.28
PLM, TANF, and CHIP Children 6 - 18	\$93.29	\$108.92
OHP Families	\$259.48	\$270.49
OHP Adults & Couples	\$476.20	\$506.79
Aid to the Blind/Aid to the Disabled with Medicare	\$536.19	\$604.14
Aid to the Blind/Aid to the Disabled without Medicare	\$777.27	\$879.79
Old Age Assistance with Medicare	\$335.25	\$342.68
Old Age Assistance without Medicare	\$612.82	\$620.13
SCF Children	\$178.29	\$281.79
CAWEM (Citizen-Alien Waived Emergency Medical)	\$69.49	\$69.81
Average	\$308.38	\$334.66
^a Includes Physical Medicine, Dental Services, Chemical Dependency and administrative costs.		
^b Includes Physical Medicine, Dental Services, Chemical Dependency, Mental Health and administrative costs.		

We have also calculated the per capita cost associated with coverage at several threshold levels on the Prioritized List of services. These estimates are calculated based on the assumption that all services up to and including the threshold ranking are covered by the demonstration project and that all services below the threshold are not covered. The per capita cost associated with ten different threshold levels are shown in Table 2 for physical health, dental and chemical dependency services and for all services combined.

Table 2
Per Capita Cost at Various Thresholds

Threshold ^a	Physical Health Services ^b	All Services ^c
317	\$235.23	\$258.58
347	\$241.47	\$265.03
377	\$256.59	\$280.81
407	\$259.65	\$283.99
437	\$264.55	\$290.14
467	\$281.04	\$307.27
497	\$287.83	\$314.06
527	\$304.41	\$330.65
557	\$308.38	\$334.66
100% Funding ^d	\$309.73	\$336.01

^a Threshold ranking on Prioritized List below which services would not be covered.
^b Includes Physical Medicine, Dental Services, Chemical Dependency, and administrative costs.
^c Includes Physical Medicine, Dental Services, Chemical Dependency, Mental Health and administrative costs.
^d Includes Lines 558, 559, 562, 564, 576, 624, and portions of Lines 615, 642, and 721. Inclusion of these lines equates to coverage through Line 566 of the Prioritized List as configured during the 2001-2003 Biennium.

Following the Legislature’s review of this report and a determination of the funding level and the services to be covered by the OHP we will refine the

calculation of the per capita cost. Changes resulting from increasing or decreasing covered services per the Prioritized List require federal approval. Once the per capita costs are finalized, we will then calculate the capitation rates to be paid to health plans participating in the program.

* * *

We appreciate the invaluable assistance provided by Oregon Department of Human Services staff, including members of the Office of Medical Assistance Programs, the Office of Mental Health and Addiction Services, the Office of Rate Setting, and members of the Actuary's Advisory Committee in developing and reviewing the methods used in calculating the per capita costs for this program.

SECTION I: Program Overview

The Oregon Health Plan Medicaid Demonstration was devised as a means of expanding the Medicaid program to additional people while constraining total health care costs. The Medicaid Demonstration is one element in the Oregon Health Plan that is intended to provide health insurance coverage to all Oregonians. Per the 1989 legislation, the Oregon Health Plan operates under the following guidelines:

1. Medicaid services are to be delivered largely through managed care entities;
2. Health plans are to be paid at “levels necessary to cover the costs of providing services”;
3. A Health Services Commission (HSC) is to develop a list of “Prioritized Health Services” that will serve as the decision making tool for determining the level of covered services;
4. Should budget shortfalls develop, adjustments to the Medicaid budget are to be made by means of changing the level of covered services rather than by changing provider reimbursement levels or by changing the eligibility rules.

Oregon’s Office of Medical Assistance Programs staff engaged PricewaterhouseCoopers to develop expected per capita costs under the Oregon Health Plan (OHP) to assist in the legislature’s decision making. This report describes the methods used in our analysis and our results.

Program Implementation

The original OHP legislation applied to the Temporary Assistance to Needy Families (TANF), Poverty Level Medical adults and children, General Assistance, and uninsured Oregonians under 100% of the federal poverty level. These groups are known collectively as the “Phase 1” population.

The “Phase 2” populations include Aid to the Blind and Aid to the Disabled (AB/AD), Old Age Assistance (OAA) and children served by the State Office for Child Welfare (SCF Children), primarily Foster Care. Because of differences in the mix of health services used and the cost to the state of providing services to individuals covered by Medicare, separate calculations are made for the AB/AD and OAA populations for those with and without Medicare coverage. These Phase 2 members became covered under the OHP in January 1995.

Under the original legislation, the OHP did not apply to Mental Health and Chemical Dependency services. Effective January 1, 1995, Chemical Dependency services were added to the Oregon Health Plan, and a phase-in of mental health services was begun on a pilot basis for 25% of the OHP population. Mental Health services were expanded statewide in July 1997.

In 1998 enrollment was expanded to include pregnant women and children in families with income up to 170% of the federal poverty level. In addition, individuals who qualify as Citizen Alien Waived Emergency Medical are explicitly identified; these individuals are eligible only for emergency medical services.

The State’s most recent waiver application proposes to make a significant change in the structure of the OHP. That proposal would extend coverage to additional individuals if funds are available in the State’s budget. The OHP population was divided into two categories:

- OHP Standard
- OHP Plus.

If the State's waiver application is approved by the Centers for Medicare and Medicaid Services, two different benefit designs will be in place for the Oregon Health Plan. The current OHP package, OHP Plus, will be provided for all mandatory and certain optional populations. The groups that will receive OHP Plus include:

- The elderly and disabled at the current eligibility levels;
- The TANF population at the current eligibility levels;
- All Medicaid and SCHIP children in the program up to 185 percent FPL;
- Pregnant women up to 185 percent FPL;
- General Assistance recipients at the current eligibility levels.

The second benefit package, OHP Standard, will provide basic coverage more similar to private insurance coverage. The initial benefit package, which includes premium sharing and copayments, has been designed to provide benefits at least actuarially equivalent to the federally mandated Medicaid benefit package.

The groups that may receive OHP Standard include those optional and expansion populations not included in OHP Plus that do not have qualified employer-sponsored insurance (ESI) available. These groups include:

- Parents and Adults/Couples below 100 percent FPL made eligible through the OHP waiver;
- Parents and Adults/Couples below 185 percent FPL made eligible through OHP2.

This report describes the development of per capita costs under the state's current waiver; a separate report will be issued that modifies these rates to accommodate the new program design.

Description of Eligibility Categories

Common Medicaid eligibility rules limit enrollment in Medicaid based on income and asset restrictions and demographic characteristics. Income limits are set at varying levels depending on the category of eligibility and are often associated with eligibility to receive a cash grant.

Eligibility groups covered under the OHP are as follows:

- The **Temporary Assistance to Needy Families (TANF)** program covers single parent families with children and two-parent families when the primary wage-earner is unemployed. For the TANF program, income limits are set dollar levels that currently reflect approximately 35% of the Federal Poverty Level (FPL). Under current eligibility rules, this category includes some former recipients with extended Medicaid eligibility.
- The **General Assistance (GA)** program covers adults who do not qualify for any of the other cash assistance programs and who are unable to work due to a medical disability for at least 12 months. The income and resource limit for the GA program is set at \$50 per month.
- The **Poverty Level Medical Program (PLM) for adults** covers pregnant women up to 170% of FPL. Those with an income below 100% of poverty are covered by the OHP eligibility rules providing reassessment of eligibility every six months, while those with an income between 100% and 170% of poverty are eligible through 60 days following the birth of their child.
- **Poverty Level Medical Children** have varying eligibility requirements depending on age:
 - Children age $0 < 1$ are covered with family income up to 133% FPL, or if they were born to a mother who was eligible as PLM Adult at the time of the child's birth;

- Children age 1 – 5 are covered up to 133% FPL; and
- Children age 6 – 18 are covered up to 100% FPL.
- Title XXI eligibles, known as **SCHIP (State Children’s Health Insurance Program)**, include uninsured children through age 18 with family incomes up to 170% FPL who are not covered by any other eligibility category.
- The Oregon Health Plan provides coverage for two eligibility groups that are not otherwise Medicaid eligible due to demographic characteristics such as single adults, childless couples and two-parent households with an employed parent. Eligibility requirements for both groups include: aged 19 and over, not eligible for Medicare, and family income under 100% FPL.
 - **Oregon Health Plan (OHP) Families** also have a child under age 19 in the household.
 - **Oregon Health Plan (OHP) Adults & Couples** do not have a child under age 19 in the household.
- The **Aid to Blind/Aid to Disabled (AB/AD)** and **Old Age Assistance (OAA)** programs apply to people who are blind, disabled, or over age 65 with an income generally below the Supplemental Security Income threshold. Many of these individuals also have Medicare coverage, offsetting a large portion of their medical costs to the State.
- **Services for Children and Families (SCF) Children** covers children age 18 and younger (a few clients are served until age 21) who are in the legal custody of the Department of Human Services and placed outside the parental home. Custody is obtained either by a voluntary agreement with the child’s legal guardian or through a county juvenile court.

- **Citizen Alien Waived Emergency Medical (CAWEM)** provides emergency medical coverage to individuals who do not qualify for Medicaid coverage due to their alien status. These individuals receive a restricted set of services, limited to emergency situations, which include labor and delivery.

Under the Demonstration Project, the TANF, GA, AB/AD, OAA and SCF Children programs are covered by the traditional eligibility rules. The PLM program for individuals with an income between 100% and 170% of FPL is also governed by the traditional eligibility rules with certain exceptions.¹ Under traditional eligibility rules for those people who qualify for a cash grant, eligibility is generally reassessed monthly for those cases where the wage earner is or has been employed in the last 12 months.

Eligibility for the “demonstration only” eligibles (OHP Adults & Couples and OHP Families), as well as those who qualify for PLM with an income under 100% of the FPL, is redetermined once every six months. For “demonstration only” eligibles, income for the month of application plus the preceding two months is averaged to determine eligibility, and household liquid assets must be less than \$2,000. Children eligible for coverage through the Children’s Health Insurance Program are covered by these same eligibility rules and, with some exceptions, must have been uninsured for the preceding six months. The CAWEM population receives eligibility for a six month period for the restricted range of services provided to that group.

Exhibit 1 provides a matrix of the eligibility categories covered under the Oregon Health Plan Medicaid Demonstration.

Expected Distribution by Eligibility Category

The per capita cost of the demonstration program is based in part on assumptions regarding the distribution of eligibles by eligibility category. For this distribution we rely upon estimates made by DHS Caseload Unit staff in their analysis of expected enrollment in the demonstration project.

¹ The eligibility rules for the PLM population with incomes from 100% to 170% of FPL are somewhat different than the rules for other categories of eligibility.

Exhibit 2 shows the expected distribution of eligibles among the eligibility categories in 2004/05. These percentages, together with expected managed care enrollment percentages provided by Office of Rate Setting (ORS) staff, are used to calculate weighted average amounts across all eligibility categories in later portions of this report.

Delivery Systems

To accommodate the contracting arrangements used by the OHP, it is necessary to calculate the expected per capita cost for discrete services for several different population groups and for several different delivery systems.

During Federal Fiscal Years 2004 and 2005 the State expects to use three different delivery systems under the Oregon Health Plan. Some health plans contract with the State to provide nearly all physical health and chemical dependency services on a prepaid, capitated basis. These plans are referred to as Fully Capitated Health Plans or FCHPs. Chemical Dependency services are integrated with the physical health contracting with the exception of one stand-alone chemical dependency organization. Dental services are all contracted on a stand-alone basis through Dental Care Organizations (DCOs); Mental Health services are contracted on a stand-alone basis through Mental Health Organizations (MHOs).

A portion of OHP members receive all services on a fee-for-service basis, with the State contracting with a Primary Care Case Manager to direct physical health services for some of these members. In addition, some portion of services continue to be provided on a fee-for-service basis during the time before an OHP member is enrolled in a health plan. Other services are provided on a fee-for-service basis for all members, regardless of the delivery system in which they are enrolled, such as non-ambulance transportation and mental health prescription drugs; maternity case management services are provided on a fee-for-service basis for all members except the limited number covered by plans which have opted to be capitated for these services. These services are referred to in this report as “FCHP/FFS” services, because they are provided on a fee-for-service basis to members enrolled in FCHP or other managed care plan.

Calculation of Cost by Delivery System

Under the Oregon Health Plan Medicaid Demonstration, payment rates vary based on whether the service is capitated or paid on a fee-for-service basis. Services that are provided through capitation contracts are priced based on “rates necessary to cover the costs of providing services,” while services that are provided on a fee-for-service basis are priced based on the Medicaid fee schedule with adjustments for expected legislative changes and payment levels.

In this analysis, we calculate per capita costs separately for capitated services, for non-capitated services for managed care enrollees, and for individuals covered by the fee-for-service and Primary Care Case Management systems. A weighted average value is then calculated based on the assumed distribution of enrollees among the delivery systems. Separate assumptions are made regarding the percentage of the population in managed care for physical health and chemical dependency, dental and mental health services.

The final per capita cost of the program will vary based on the contracting arrangements entered into between the State and prepaid plans, the demographic characteristics of the enrolled population, and the services that the Legislature determines it is able to fund.

In the following section we describe our data sources used in this analysis. In Section III we describe the methods and assumptions used in developing the per capita cost estimates and report on the estimated per capita costs for the program. Section IV describes the methods used to allocate costs to the diagnosis/treatment pairs on the Prioritized List and the resulting estimated per capita costs.

SECTION II: Data Sources

Primary Data Sources

Four primary claims data sources were used for the analysis: encounter data reported by participating health plans to the Office of Medical Assistance Programs (OMAP), encounter drug data reported directly by some of the FCHPs to First Health Services (a national health benefits company used by OMAP for pharmacy benefits management), fee-for-service data from the Oregon Medicaid Management Information System, and data on special behavioral health services from the Office of Mental Health and Addiction Services (OMHAS). In addition, detailed eligibility data are used. Each of the data sources is described below.

- **Encounter** data reported to OMAP are used as the basis for the calculation of FCHP, DCO and MHO capitation rates. Claims incurred between July 1, 1999 and June 30, 2001 served as the primary data source for this portion of the analysis.
 - A single data set was provided with inpatient, outpatient, physician, mental health, and dental claims. Each claim contained the health plan's reported billed charge amount; paid amounts were not reported in this data set. Each claim also included procedure codes, diagnosis codes, and patient demographic information such as date of birth, gender, and eligibility category.
 - Health plan data was summarized by plan, eligibility category and service category and provided to the respective plans for review and validation against their internal financial

information. Through this process, the data for all health and dental plans were used. The data of one mental health plan was not used in this analysis because it was believed to represent significant levels of under-reporting of encounters. Data from 11 MHOs, representing 92.8% of MHO members, were included in this analysis.

- **FCHP Prescription Drug** data were procured through a separate data request directly to health plans, as this information is not captured by OMAP in its encounter data reporting system. Drug data was provided by only 5 health plans covered varying time periods depending on what was available and most credible. Appropriate member months of enrollment were matched against each plan's prescription drug reporting period. The encounter drug data used for these per capita cost calculations represents 39% of FCHP members.
- **Oregon Medicaid Management Information System (MMIS)** data are used to estimate fee-for-service system utilization rates by eligibility category and service type. Data for July 1, 1999 through June 30, 2001 were provided, including data for institutional, non-institutional, dental and prescription drug data. All of the data included actual billed and paid amounts for all services. Diagnosis and procedure codes were also provided, as well as patient information such as date of birth, sex, and category of eligibility.
- **Office of Mental Health and Addiction Services (OMHAS)** data are used for measuring the cost of mental health services, in addition to MMIS data. Certain services provided by the MHOs are not reported in the encounter system. These services are known collectively as Prevention, Education, and Outreach (PE&O). Some of these services are provided on an individual basis, while others relate to broad community-based services. We consulted with OMHAS staff to determine those services that could appropriately be considered covered services and

included in the per capita cost development and future capitation rates.

- **Eligibility information from the MMIS** is used to identify the specific eligibility and enrollment for each individual and to determine the correct number of eligibles associated with each service. Date sensitive matching is done between the state's master eligibility file and the enrollment database that describes the health plans in which each individual is enrolled at any point in time. These data provide information on each individual's eligibility classification, start and end date of the span of eligibility, and enrollment in plans.

As described above, different data sources are used for various components of the calculation. However, the data are used primarily in a mutually exclusive manner. For example, encounter data are used for calculating utilization rates for physical health capitated services, while fee-for-service data are used for calculating comparable rates for services paid on a fee-for-service basis. In no place in the analysis do we add data together from multiple sources for a particular portion of the calculation. Per capita costs are developed for each component of the calculation, and then the per capita costs are added. Throughout the process, care is taken to avoid double counting. This process is facilitated by using discrete service categories and population groups.

A portion of services for managed care enrollees is paid on a fee-for-service basis. These services relate primarily to mental health drugs, and case management and special services, such as school-based health services. No comparable service categories exist in the encounter database.

Other Data Sources

Data on cost-to-charge ratios for hospital services in Oregon were obtained from OMAP. Information on Medicare payment levels was used for calculating cost-to-charge ratios for professional services and other services that are covered by the Medicare program. In addition, we relied on data

from the federal Centers for Medicare and Medicaid Services Office of the Actuary and Express Scripts, Inc. for estimating trend rates.

SECTION III: Methods and Assumptions

Generally Accepted Methods for Calculating Capitation Rates

Capitation rates are generally calculated by multiplying the rate of utilization of covered services by the average payment per unit of service. The utilization rate is typically expressed in terms of the number of services provided in a program per 1,000 eligibles (or enrollees) per year. The number of eligibles per year is typically expressed in terms of member-months of eligibility. Thus, a person eligible for the entire year would have twelve member-months of eligibility, while a person eligible for only half of the year would be counted as having six member-months of eligibility.

For example, the amount to be paid for covered inpatient services would generally be expressed in terms of the number of inpatient days or the number of admissions per 1,000 members per year. This utilization rate is then converted into a measure per person per month by dividing by 12,000. The average payment (or reimbursement) per unit of service is then multiplied by this utilization rate to determine the per capita cost per month for that service. Similar calculations are made for the other categories of service, and appropriate adjustments are applied to reflect changes in covered services, eligibility, or the change in the cost per unit of service over time.

The sum of the required per capita costs for all contracted services is the total per capita cost for health care services. This analysis shows separate per capita costs for 14 different eligibility categories. Some changes in the grouping of eligibility categories have been made to result in capitation rate categories that contain members with similar risk characteristics. The TANF children have been grouped with PLM and CHIP children of similar ages.

TANF adults now have their own rate category. Plans are also paid an allowance for administrative expenses.

Methodology Used in Calculating Per Capita Costs

The per capita cost amounts through Line 557 of the Prioritized List are calculated through a multi-step process, which is briefly described below. Each of the steps is then described in greater detail.

1. Data from each of the data sources is summarized by eligibility category and service category. From this process we obtain information on total charges (encounter data), total paid amounts (fee-for-service data), and total units of service for the data period (encounter and fee-for-service data).
2. Adjustments are made for missing or problematic data or data that is included in the database but not relevant to the per capita costs. These adjustments are referred to as “data issues”.
3. Adjustments are made for changes in covered services or other changes expected to occur during the contract period. These adjustments are referred to as “budget issues”.
4. Common measures of estimated cost or charges are calculated including the charges per person per month, the paid amount per person per month, and the number of units per 1,000 people per year. For the units per 1,000 people per year, a person is assumed to represent 12 member months. Thus, it is not possible to estimate the number of unique people accounted for in the calculation, and for eligibility categories with relatively short lengths of eligibility and episodic cases, such as maternities for the PLM adult population, it is possible to have more than one calculated average case per person per year.

5. Trend rates are calculated that apply to the appropriate payment method and population group.
6. Cost-to-charge ratios by service category are calculated and applied to encounter data for services that are paid on a capitated basis. (For services provided on a fee-for-service basis, the average Medicaid paid amount is used in the per capita cost calculation.)
7. Total expected costs per person per month are calculated for each eligibility category and service delivery arrangement.
8. The population distribution estimated for the contract period is arrayed by eligibility category and contract arrangement based on projections made by DHS Caseload Unit and Office of Rate Setting staff.
9. The per capita cost for the Oregon Health Plan is calculated based on the expected population and contracting mix.
10. Costs are allocated to the various line items of the Prioritized List based on assignment criteria described in detail in Section IV. Separate allocations are made by eligibility category and broad service category (physical health, dental, chemical dependency, and mental health).

Measuring Utilization and Average Charges by Category of Service

The first step in this analysis is the categorization of claims into the approximately 95 detailed service categories shown in the attached exhibits. Claims are assigned to these categories based on the detailed criteria described in OMAP's "bucket books" for encounter and fee-for-service data.

The next step involves calculating utilization rates and the charge or payment amount per unit of service for each category of service, with the data subset for each eligibility category. The encounter data serves as the primary data source for the analysis of capitated services, with Medicaid MMIS data

forming the basis of non-capitated services and periods of eligibility. Average charges are therefore calculated from the encounter data and average payment amounts are calculated from the fee-for-service data. Amounts paid by health plans to providers are not reported on the encounter database.

Utilization rates are measured by counting all claims for each of the categories of service. The sum of the number of claims is then divided by the number of member months of enrollment for the appropriate population group.

Hospital claims are recorded on a per admission basis, while all other claims are recorded for each separate service that is provided. For example, a series of office visits for a single condition are counted separately for each visit rather than as one episode of illness. Each separate prescription is also counted.

Exhibits 3-A (encounter) and 3-B (fee-for-service) show a comparison of the utilization rates by general category of service for each of the Medicaid eligibility categories after adjustments for changes such as the “budget issues” described in the preceding section.

Translating Average Charges to Measures of Cost

The Oregon Health Plan requires that the capitation rates for the program be based on “rates necessary to cover the costs of services.” In previous reports on per capita costs² we developed a method for defining costs based on a combination of cost-to-charge ratios for hospital services, the Medicare Resource Based Relative Value Schedule for professional services, and managed care contracting rates. We have largely retained those same methods for this analysis, with some exceptions for specific services.

The charges per unit of service developed from the encounter data are adjusted to estimate a measure of “cost” for each general category of service based on a cost-to-charge ratio. Adjustments unique to each of the categories

² Coopers & Lybrand and PricewaterhouseCoopers reports dated May 1, 1991, April 19, 1993, February 10, 1995, December 16, 1996, December 8, 1998, and September 21, 2000.

of service are made to translate the average charge amounts to values that would reflect “rates necessary to cover costs.”

Data on hospital costs and charges are reported to state agencies, from which average cost-to-charge ratios are calculated. These ratios are used to adjust the average charge amounts for inpatient and outpatient hospital services to the costs for those services.

For other categories of service, there are no generally accepted means of determining the “cost” of providing services. As a substitute, we examined published information on the percentage of total gross revenue (or charges) used to cover overhead expenses where that information is readily available as a first step in estimating the relationship between average charge amounts and the costs associated with providing services. We also examined payment rates made by Medicare and information on loss ratios reported by OHP health plans.

In past reports, we have used the Medicare fee schedule as a benchmark for the costs for other services. For the FFY 2004-05 per capita cost development, we have continued this methodology using the 2002 Medicare fee schedule to derive imputed costs. We used the relationship between payment rates for specific services in the Medicare fee schedule to develop cost-to-charge ratios for each of the professional service categories. Exceptions were made for Maternity and Newborn services, as those services are not well represented in Medicare’s data. Extraordinarily low implied cost-to-charge ratios resulted from our application of the Medicare payment methodology for those services. As a substitute, we assigned the value calculated for Physician Office Visits for those service categories.

For dental services, we do not apply a discount factor. Based on discussions with dental care organizations and our review of the data, we believe the encounter data reflect the amounts paid by DCOs for services rather than a charge amount.

For mental health plans, the reported amounts generally reflected the fee-for-service Medicaid fee schedule. These amounts are below the plans’ cost of

providing services. One plan recently undertook a cost allocation analysis, and these amounts were used as the MHO cost benchmark in our analysis.

As described in Section II, prescription drug data was provided by certain participating health plans directly for this analysis, as OMAP did not collect this data during the data period. The plans did not provide pharmacy payment amounts as this was considered to be proprietary information. Therefore, First Health processed the encounter data using OMAP's pharmacy payment levels as the reported cost. We surveyed the plans to obtain information to allow us to estimate the average discounts, dispensing fees, rebates, and administrative costs negotiated by the plans with their PBMs. Based on information obtained from six plans, the plans are receiving rebates ranging from 2% to 6%, discounts ranging from 13% to 27% off Average Wholesale Price (AWP), dispensing fees ranging from \$2.25 to \$2.75 per script, and basic administrative fees ranging from \$0.19 to \$0.65 per claim. The prices reflected in the First Health data are based on OMAP dispensing fees of \$3.80, discounts of 11% off AWP, and no administrative fees or rebates. Based on this information, we developed an adjustment, a 5% reduction, that was applied to the reported costs to reflect the estimated difference between the plans' costs and the OMAP reimbursement levels reported by First Health.

For three service categories: Transportation – Ambulance, Durable Medical Equipment and Supplies, and Home Health, we conducted research on the methods used by Medicare to determine payment. For each of these services we developed a payment formula equal to the formula used by Medicare with limited exceptions where the data elements needed to calculate the implied Medicare payment amount were not available in the encounter data. These data elements would have allowed finer differentiation in the calculation, but were determined to have only a nominal impact on the resulting calculations.

Where Medicare data are used as a benchmark for comparison, the calendar year 2002 fee schedules are used. The 2002 Medicare RBRVS fee schedule represents an approximately 5.4% reduction from the 2001 fee schedule. An additional reduction of 4.9% is scheduled to take effect in 2003; we have not adjusted the implied payment rates to account for this expected reduction.

For individuals who are dually eligible for Medicare and Medicaid, health plans are responsible only for that portion of costs that are not covered by Medicare.³ The billed amounts included in the encounter data reflect 100% of charges for the encounter, and do not include an offset for Medicare payments. We calculated cost-to-charge ratios for individuals with Medicare coverage by examining differences in the OMAP fee-for-service payment amount for the AB/AD population with and without Medicare coverage and the OAA population with and without Medicare coverage. The ratio of the payment amount, with a maximum value of 1.0, was applied to the standard cost-to-charge ratio to determine the cost-to-charge ratio for service provided to individuals who are dually eligible for Medicare and Medicaid.⁴

The cost-to-charge ratios used in the analysis are shown in Exhibit 4.

Malpractice costs in Oregon have increased significantly in the past 18 months. Insurance premium increases for obstetricians have been particularly high. A calculation of the increased cost per delivery attributable to increased malpractice insurance costs was estimated to be approximately \$300 per maternity delivery. An analysis performed by ORS staff indicated that this results in an increase in reimbursement for maternity services of 31.6% based on the Medicaid fee schedule. We applied this adjustment to the Physician – Maternity category of service for the fee-for-service delivery system. The FCHP maternity malpractice adjustment was calculated relative to the 2002 Medicare Physician Fee Schedule since it is used as the benchmark for FCHP Physician reimbursement in the per capita cost development for FFY 2004-05. The calculated adjustment to the Physician – Maternity category of service for the FCHP delivery system was 1.257. In recognition of the requirement to pay health plans at rates necessary to cover the costs of providing services, additional adjustments to the managed care

³ OHP plans with Medicare Risk contracts are responsible for all costs, but the services that are covered under the Medicare scope of services are assigned to their Medicare line of business.

⁴ Under both the FFS and FCHP delivery system, many providers choose not to submit claims for services when no payment is anticipated. For example, if Medicare payment is higher than the Medicaid allowed amount, providers often do not submit a separate bill to Medicaid, since the payment amount would be \$0. We confirmed with managed care plans that similar practices occur in that setting, and that the encounter data can be expected to show similar patterns in costs per unit of service. Where the cost-to-charge ratio for services provided to Medicare recipients is equal to the cost-to-charge ratio for non-Medicare recipients, this circumstance is prevalent.

rates were made for recent increases in malpractice premiums. It is our expectation that the costs for increased malpractice premiums are being passed on to the plans through higher negotiated physician reimbursement rates.

“Data Issues”

Several adjustments were made for missing data, changes in policy during the data period, problems with data submissions, or services that are reported in the data but are not the responsibility of the OHP. These adjustments are described below.

IBNR

The claim and encounter data represents services incurred July 1, 1999 through June 30, 2001. The data includes fee-for-service claims adjudicated by OMAP and managed care encounters submitted by managed care plans and processed by OMAP through January 2002. Claims and encounters paid or submitted after this date are not included in the dataset. Therefore, an adjustment for incurred but not reported (IBNR) claims and encounters is necessary to fully reflect the services provided during the data period.

For the fee-for-service claims, the data included both dates of service and dates of payments. We used this data and generally accepted actuarial methods to estimate the value of the IBNR claims by analyzing the historical claim payment patterns.

For the encounter data, the dates of payment were not available. Therefore, OMAP provided us with the value of encounters submitted and processed subsequent to the January 2002 process date, which our data included. Using this information, we developed IBNR adjustments to the encounter data.

Missing Dental Service Encounters

The encounter data we received for one dental plan had several “gaps”. Data is submitted to OMAP approximately twice per month. Therefore, there are 48 possible data submissions over the 24 month data period. It appeared that we were missing 8 data submissions from that plan. Therefore, we applied a 20% increase ($48 \div 40$) to the plan’s utilization data. This resulted in an overall adjustment to the dental encounter data of approximately 2.4%.

Mental Health Acute Care Days

The mental health encounter data includes days reported by the MHOs, but paid by the state for long term care patients. The cost of these days is not the responsibility of the MHOs. Office of Rate Setting staff performed an analysis, matching the names of patients in the encounter data to names in the OMHAS payment records. Through this process, OMHAS identified approximately 4.1% of mental health acute care inpatient days that were paid by the state and should not be included in the OHP per capita cost development. We applied an adjustment of 0.959 ($1 - .041$) to the Mental Health Acute Care utilization.

FCHP Drugs

Encounter drug data was submitted by several FCHPs and processed by First Health. Through its data processing, First Health determined that approximately 11.9% of the encounters were invalid for various reasons. Of these, approximately 95% failed because the patients appeared to be ineligible at the time the drug was dispensed. The other 5% of failed encounters were determined to be invalid for other reasons, such as invalid NDC codes. A subsequent analysis by ORS staff determined that approximately 93% of those encounters rejected for eligibility reasons should not have been rejected. We applied a pro rata adjustment of 11.9% ($278,958$ incorrectly rejected encounters divided by $2,345,307$ accepted encounters) to the encounter drug utilization provided by First Health to adjust for the incorrectly rejected encounters. First Health did not price encounters that were rejected. Therefore, we assumed that the average cost per script for the rejected claims was equivalent to the average cost per script for the accepted

claims. An analysis performed by ORS staff confirmed that this was a valid assumption.

Duplicate Claims and Encounters

OMAP employs a variety of data “cleanup” processes to the claim and encounter data. These processes include the identification and removal of duplicate claims and encounters. Through PwC data analyses, we found additional duplicate claims and encounters and confirmed their presence with OMAP staff. These duplicate records, valued at 0.2% of billed charges were removed from the data.

“Budget Issues”

Certain adjustments are made for changes in covered services or other changes expected to occur during the contract period; these adjustments are referred to as “budget issues”. These data were provided by OMAP for both fee-for-service and managed care delivery systems issues, and reflect the following items:

Service Category	Budget Adjustment	Delivery Systems Affected
• Ambulance	Ambulance reimbursement	FFS
• Ambulatory services	Ambulatory services copayment	FFS
• Anesthesia	Anesthesiology reimbursement	FFS
• Chemical dependency	DUII treatment	FFS and Managed Care
• DME/Supplies	Incontinent supplies reimbursement	FFS
• Mental Health	Child Welfare Assessment and Follow-ups	FFS and Managed Care
• Mental Health Drugs	Case management for antidepressants	FFS
• Physical Health	Case management for most expensive clients	FFS
• Physical Health	Disease state management	FFS
• Prescription Drugs	Practitioner-managed prescription drug plan	FFS
• Prescription Drugs	Maximum allowable charge	FFS
• Prescription Drugs	Pharmacy copayments	FFS
• Prescription Drugs	Pharmacy lock-in	FFS
• Prescription Drugs	Pharmacy reimbursement and dispensing fees	FFS

An important policy change is the introduction of copayment requirements for certain ambulatory services and prescription drugs. The copayments on medications will be \$2 for generic drugs and \$3 for brand-name drugs, and the copayment for specified ambulatory services will be \$3. In compliance with 42 CFR 447.53(b), individuals through age 18, pregnant women, institutionalized individuals, emergency services, family planning services and supplies, and services provided by health plans will be exempt from copayment requirements. Copayments will be collected by providers;

however, those members who indicate to the provider that they cannot pay the copayment at the time the service is provided cannot be refused services.

Adjustments for Services Not Reported in Encounter Data

During the data reporting period Mental Health Organizations were expected to provide specific types of ancillary services, including Prevention, Education, and Outreach (PEO), as well as other Ancillary Services. Specific reporting protocols had not yet been developed to allow the utilization of these services to be tracked through the encounter data reporting system. MHOs provided separate reports of these activities, which were subject to review by OMHAS staff. Those services that were considered similar in nature to Exceptional Needs Care Coordination were included in the calculation. The MHOs provided data showing expenditures for the following specific categories of service:

- PEO1 - Public Information,
- PEO2 - Community Education,
- PEO3 - Parent/Family Education,
- PEO4 - Alternative Activities
- PEO5 - Community Mobilization,
- PEO6 - Life Skills Development,
- PEO7 - Prevention Support Activities,
- PEO8 - Community Based Outreach, and
- PEO9 - Services Integration.

The costs related to PEO3, PEO6, PEO7, and PEO9 were deemed to be attributable to services provided to individuals, and therefore, could be reasonably considered as healthcare costs. These categories represented approximately 60% of the total PEO costs reported by the plans for calendar

year 2001. In addition, \$1,167,000 in Treatment Support Services was determined to be reasonable non-encountered costs. The total adjustment for PEO and Treatment Support Services was \$0.57 PMPM.

Method for Trending Data Forward to FFY 2004/05

The cost per unit of service for all categories of service is trended forward to reflect the contract period of October 1, 2003 through September 30, 2005. Total trend rates are made up of two components:

- the increase in cost per unit of service (cost trend), and
- the increase in the number of units of service provided, in the relative intensity of services provided, and in the level of new technology used to provide medical services (utilization trend).

The trend rates in this analysis are calculated using two different approaches to reflect the differences in contracting arrangements and payment rates under the OHP. In addition, separate trend rates are developed for members with and without Medicare coverage. The trend rates used in this analysis can be found in Exhibits 6-A and 6-B for managed care and fee-for-service, respectively.

The trend rates for managed care calculations are based on a combination of data including the following three key data sources:

1. Information reported by the Centers for Medicare and Medicaid Services (CMS), Office of the Actuary in their projections of national health expenditures,⁵
2. Regression models based on health plan encounter data that measure rates of change in utilization of services and billed charges per member per month, subset by major eligibility category and service type; and

⁵ Cost trends can be found in Tables 3a, 4a and 5a at www.hcfa.gov/stats/NHE-Proj/tables/default.htm. Total trends are reported in Tables 10 and 13 at www.hcfa.gov/stats/indicatr.htm.

3. Published reports on expected rates of change in per capita costs for prescription drugs.

Where CMS data are used, we have generally applied the measure of expected change in the “commercial” portion of the CMS report. For managed care dental services, the “total” (all payer) CMS expenditure information is used, as dental services have a higher level of patient copay requirement in commercial plans than would be experienced in the OHP. The utilization trends are adjusted to reflect observed trends for inpatient, outpatient, and physician services.

Where appropriate, we have used the health plan experience during the data period, and the CMS trend projections for the future.

Separate trend rates are calculated for each year and then combined to develop annualized trend adjustments.

Trend rates for the fee-for-service delivery system are developed based on expected cost increases provided by OMAP and a calculation of total trend based on OHP experience during our data period. Utilization trend is derived by subtracting the cost trend value from the total trend.

Administrative Cost Allowance

The total program cost for the Fully Capitated Health Plan (FCHP) portion of the calculation includes an 8% allowance to cover administrative expenses. 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. Administrative costs of 8% are also paid for Dental Care Organizations, Mental Health Organizations, and the Chemical Dependency Organization as well as for the chemical dependency services covered by Fully Capitated Health Plans. The administrative cost allowance is typically reported as a percentage of total premium and the amount allocated for administrative costs shown here for the FCHP portion of the program is expressed in those terms.

We reviewed plan financial reports and confirmed that, on average, reported administrative costs ranged around 8%. For the fee-for-service portion of the program we have included a case management fee to be paid to the Primary Care Case Managers for the portion of the population enrolled with PCCMs.

Adjustments for Non-Covered Services

Under the OHP, only those diagnoses and treatments on the Prioritized List through the approved funding line are considered to be covered by the program. Our examination of the data showed some services in both the FFS and encounter data that presumably were not eligible for coverage. Under the FFS system, services that are considered to be associated with a higher funding line and that represent comorbidities are allowed. Based on these decision rules, we assumed a comparable level of services in the encounter data system would also be allowed despite their having been identified as being below the funding line.

We conducted a thorough analysis of the encounter data for certain health plans to assess the prevalence of claims that appear to represent services that should have been disallowed based on the Prioritized List. We found numerous records that were for non-specified, or apparently non-covered services. However, on further review of the data, we found those services were largely related to initial diagnostic visits, as allowed under the Oregon Health Plan, or were associated with covered, comorbid conditions. While we believe improvements in coding should be made to more clearly identify the reason for coverage for services that appear to be non-covered, we have included 100% of both the fee-for-service and encounter data in the calculation of expected costs.

Line 566 of the 2001/2003 Prioritized List

Both the fee-for-service and encounter data described above provide information on the services provided under the OHP during the period July 1999 through June 2001. During the data reporting period, the OHP covered services only through line 566 of the 2001-2003 prioritized list. Services

matching condition/treatment pairs below line 566 were not covered by the program and are not represented in the data used here.

Given the lack of any recent claims information below line 566 of the 2001-2003 list, and the likelihood that the legislature will continue to fund services at this line or above, these calculations have not been expanded to cover services below this line. If additional services are funded, additional calculations will be performed at that time to determine the added cost.

Final Per Capita Costs through Line 557 of the Prioritized List

Exhibits 7-A (managed care) and 7-B (fee-for-service) show the detailed calculation of per capita costs through Line 557 of the Prioritized List for each of the population groups with the expenditures trended to FFY2004/05. These per capita costs reflect the expected claims costs per person per month under each delivery system. Fee-for-service costs for managed care enrollees are shown in Exhibit 8. Administrative costs for managed care plans or for Primary Care Case Managers are reflected in the appropriate section of Exhibit 8 and in Exhibits 10-A through 10-F.

The per capita cost for the demonstration period is based on the distribution of enrollees by eligibility category and health service delivery system. Exhibits 9-A through 9-C show the expected population distribution during FFY2002/03; these estimates were provided by DHS Caseload Unit staff.

Exhibits 10-A through 10-F show the expected per capita cost for the Oregon Health Plan through Line 557 of the Prioritized List, based on the per capita costs developed in Exhibits 7-A and 7-B and the expected population distribution from Exhibits 9-A through 9-C.

SECTION IV: Pricing the Prioritized List of Services

Introduction

The final per capita cost for the program will be based on the specific services that the Legislature determines will be covered and the population distribution by eligibility category and delivery system. The rate calculated thus far shows costs through Line 557 of the prioritized list. However, the Legislature may decide that funds are not available to fully cover all health care services through that level. Alternatively, the legislature may fund services beyond Line 557. The data available for this analysis did not permit an accurate calculation of costs beyond Line 557.⁶ Should additional funding become available to expand services, additional data and analysis will be required to calculate the added costs and new funding threshold.

Process for Identifying Expenditures by Condition/Treatment Pair

To determine the per capita costs associated with covering a portion of health care services, we used the condition/treatment pairs developed by the HSC. All of the non-pharmacy expenditures in our databases were allocated to the line items in the Prioritized List of services, with minor exceptions.⁷ The specific process used for allocating expenditures to line items is described

⁶ The data underlying the calculation of the per capita costs includes coverage of services through Line 566 of the Prioritized List as configured during the 2001-2003 Biennium. Coverage through Line 557 of the Prioritized List as configured during the 2003-2005 Biennium excludes Lines 558, 559, 562, 564, 576, 624, and portions of Lines 615, 642, and 721, which were previously covered.

⁷ A small percentage of the expenditures in the FFS and encounter data bases (between 7% and 8% of the total) did not match any of the criteria for assigning expenditures to one of the line items.

below.⁸ Separate analyses were performed for the encounter and FFS databases.

Types of Condition/Treatment Pairs

The HSC developed condition/treatment pairs based on combinations of ICD9 diagnosis codes and CPT-4 procedure codes. For mental health services, ICD-9-CM diagnosis codes and OMAP-specific “BA” procedure codes are used, and for dental services CDT-3 procedure codes are used. In the Prioritized List, the same diagnosis code is often associated with different types of treatments. The primary distinction is among treatments that include a surgery and treatments that are primarily medical in nature. Surgery claims are generally defined by CPT-4 codes in the range of 10000-69999. Medical Therapies are generally defined by CPT-4 codes in the range of 90000-99999. The remaining CPT-4 codes describe Dental (CDT-3 codes D0100-D9999), Anesthesia (codes 00100-01999), Radiology (codes 70000-79999) and Pathology and Laboratory (codes 80000-89399) services.

In addition to the services that can be identified based on specific combinations of condition/treatment pairs, there are a large proportion of services that are coded based on something other than CPT-4 code. These include ancillary services as well as hospital inpatient and outpatient services and prescription drugs. In addition, the HSC did not specifically identify the laboratory tests, x-rays, anesthesia, or other ancillary services that are associated with each of the condition/treatment pairs because of the large amount of overlap that occurs (i.e., the same codes would be used for nearly all of the line items).

Initial Diagnosis

Expenditures associated with initial diagnosis are always covered and thus included at the beginning of the list. These expenditures are identified as

⁸ The term “line item” is used to describe the condition/treatment pairs developed by the HSC for the Prioritized List.

those with ICD9 codes in the range of 780 through 799, or several other ICD9 codes that are primarily diagnostic in nature, or with CPT-4 codes identified by the HSC as being associated with initial diagnosis. These treatments include biopsies and other diagnostic procedures as well as most lab and x-ray services. A few services, such as Targeted Case Management, Exceptional Needs Care Coordination, and Transportation – Other are allocated to the beginning of the list because diagnostic information is not available and they are assumed to be always covered.

Medical and Surgical Therapies

Medical Therapies are those services that do not include a surgery. These services are coded with CPT-4 codes in the range 90000-99999 (excluding those ranges uniquely associated with a Prioritized List line item). An issue in developing the condition/treatment pairs is that many of the diagnoses have a primary treatment that is medical only and a companion treatment that is primarily surgical. For example, for most cancer diagnoses, patients can receive either medical therapy or surgical therapy. In addition, in some cases the range of diagnoses on the Prioritized List provided for a given condition/treatment pair includes some diagnoses that occur for another line item with the same treatment. In other cases, the patient's age or stage of disease is used to differentiate between condition/treatment pairs. In either of these cases the same services could theoretically be allocated to more than one condition/treatment pair, so we developed decision rules for allocating the expenditures to each pair.

The classification imposed by the current coding system is such that some claims have the potential of falling into more than one of the line items on the Prioritized List. For example, individuals who receive a surgical therapy also generally have some expenditures that may be associated with medical therapy. This issue is most clearly defined for those conditions that have one line item for medical therapy and one line for surgical therapy. For example, individuals with heart failure can be treated with a heart transplant (surgical treatment) or can be treated by non-invasive medical therapy. Similarly, patients with stomach ulcers may receive either surgical or non-invasive

treatment. An analysis of members with ulcers and heart failure indicates that approximately 25% of the expenditures associated with medical therapy (services with CPT-4 codes in the range of 90000-99999) are for members who received surgical treatment. The remaining 75% of medical therapy CPT codes are associated with members who did not receive a surgical treatment.

To allocate the physical health expenditures to each of the line items we used the following logic:

1. We identified all claims as fitting into one of several general categories:
 - i. Claims with CPT-4 or ICD9 codes that were identified as “always covered” by the HSC or were otherwise deemed to be always covered. These claims were placed on “line zero”.
 - ii. Claims with codes in a range that we expected to match exactly with at least one of the condition/treatment pairs.
 - iii. Claims with codes in a range that we did not expect to match exactly with one condition/treatment pair.
 - iv. Claims associated with services that were deemed by the HSC to be “never covered”. These claims were deleted from the database for purposes of assigning costs to lines.
2. Claims with service codes that we expected to exactly match a line item on the Prioritized List were further divided into two groups: those that represented surgeries, mental health, or dental, and those that did not meet any of these criteria. Surgery claims were identified as those with CPT-4 codes in the range of 10000-69999. Mental Health therapies were identified by CPT-4 codes 90801-90899, 96100, 99052, 99201-99275, 99291. Dental claims were identified by the presence of a

CDT-3 code on the claim. Claims with all other procedure codes were identified as medical.

3. Surgery, mental health and dental claims were matched against the Prioritized List and allocated to a specific line item when possible.
4. Medical claims and claims without procedure codes were matched to determine the first five line items with which the expenditure could be associated based on primary ICD9 code alone.
5. For the claims matched in step 4 that did have medical CPT-4 codes, we then determined whether any of the line items represented only “Medical Therapy”. Medical Therapy lines are identified by the HSC.
6. In cases where the claim’s ICD9 code matched exactly two line items, one of which represented “Medical Therapy” and the other of which represented a form of surgery, 75% of the medical therapy expenditures were allocated to the “Medical Therapy” line item and 25% of the medical therapy expenditures were allocated to the surgical therapy line item based on our analysis of the “Medical Therapy” expenditures for individuals with Heart Failure and Ulcers.
7. In cases where the ICD9 code matched several line items, all of which represented “Medical Therapy”, the expenditures were distributed equally based on the number of line items.
8. In cases where the ICD9 code matched several line items, all of which represented various surgical therapies, the expenditures were distributed equally based on the number of line items.
9. In cases with multiple medical therapies and one or more surgical therapies, 75% of the medical expenditures were allocated to the medical therapy line items, with the

expenditures allocated to each line based on the number of medical therapy lines. The remaining 25% of the medical therapy expenditures were allocated to the surgical therapies, with the expenditures allocated equally to each line based on the number of surgical therapy lines.

10. For the claims matched in step 4 that did not have medical CPT-4 codes, including inpatient hospital, outpatient hospital coded without HCPCs, the expenditures were proportionally distributed across all matched lines to the total dollars by line of claims matched in steps 4 through 9.
11. All allocated services were then summarized to obtain total amounts by line item. Separate totals were calculated for each of Chemical Dependency, Mental Health, Dental, and Physical Health claim types.
12. The total dollars for prescription drug expenditures by line item were calculated separately based on the results of the global per capita cost calculation. From that analysis we identified the percentage of physical health costs associated with prescription drugs for each eligibility category. The prescription drug dollar amount on each line was calculated by multiplying this percentage by the physical health costs that were allocated to the line through the process described above. (Prescription drug claims do not include diagnosis codes so it is not possible to directly match the expenditures to specific condition/treatment pairs.) A separate calculation is made for mental health drugs and the costs are assigned to the appropriate mental health and chemical dependency lines on the prioritized list.
13. The expenditures were then summed across all line items to obtain a total dollar amount.

14. The percentage of total dollars represented by each line item was calculated by dividing the dollars for the line item by the total dollars for the entire database.
15. We then calculated the cost per person per month, by delivery system, by multiplying the percentage of the total represented by each line item by the total cost per person per month shown in Exhibits 7-A and 7-B.

The above methodology was used separately for costs under managed care plans (FCHPs, DCOs and MHOs), under the fee-for-service/Primary Care Case Manager system, and also for services provided to managed care enrollees on a fee-for-service basis. Within each delivery system, separate percentages were calculated for each eligibility category for each line of the Prioritized List. Weighted average percentages were then calculated by delivery system across all eligibility categories for physical medicine, Chemical Dependency, Dental and Mental Health services.

Exhibit 11 provides a summary of the criteria used for assigning claim dollars to each of the condition/treatment pairs.

Calculating the Cost Per Person Per Month Based on Covered Services

The cost per person per month for several “threshold” levels of services was calculated by determining the services that would be above and below the line at each threshold. These thresholds were identified by their rank on the Prioritized List.

The cost per person per month at each threshold was calculated by summing the cost per person per month for each line item through the threshold. In other words, for the threshold at line 377, all lines from 1 through 377 were summed. Exhibits 13-A and 13-B show the per capita cost at each of the ten threshold levels based on the expected eligibility distribution for the OHP under each delivery system. Per capita cost estimates are shown separately

for broad service categories. Exhibit 13-C shows total program costs at these threshold levels across all eligibility categories and delivery systems.

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Description of Eligibility Categories

	2002-2003 Definition	2004-2005 Definition
Temporary Assistance to Needy Families	Recipients of Temporary Assistance to Needy Families under current eligibility rules (including former recipients with extended Medicaid eligibility)	Recipients of Temporary Assistance to Needy Families under current eligibility rules (including former recipients with extended Medicaid eligibility)
General Assistance	Recipients of state General Assistance grants	Recipients of state General Assistance grants
PLM Adults	Pregnant women with family income under 170% of FPL and not eligible for cash assistance	Pregnant women with family income under 185% of FPL and not eligible for cash assistance
PLM Children under 1 year	Children under one year of age with family income under 133% FPL or born to mothers who were eligible as PLM Adults at the time of the child's birth; and not eligible for cash assistance	Children under one year of age with family income under 133% FPL or born to mothers who were eligible as PLM Adults at the time of the child's birth; and not eligible for cash assistance
PLM Children 1 through 5 years	Children aged at least one but less than six years with family income under 133% FPL and not eligible for cash assistance	Children aged at least one but less than six years with family income under 133% FPL and not eligible for cash assistance
PLM Children 6 through 18 years	Children aged at least six but less than nineteen years with family income under 100% FPL and not eligible for cash assistance	Children aged at least six but less than nineteen years with family income under 100% FPL and not eligible for cash assistance
OHP Adults & Couples	Eligibles aged 19 or over and not Medicare eligible with income below 100% FPL who do not meet one of the other eligibility classifications, and do not have an unborn child or a child under age 19 in the household	Eligibles aged 19 or over and not Medicare eligible with income below 100% FPL who do not meet one of the other eligibility classifications, and do not have an unborn child or a child under age 19 in the household

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Description of Eligibility Categories

	2002-2003 Definition	2004-2005 Definition
OHP Families	Eligibles aged 19 or over and not Medicare eligible with income below 100% FPL who do not meet one of the other eligibility classifications, and have an unborn child or a child under age 19 in the household	Eligibles aged 19 or over and not Medicare eligible with income below 100% FPL who do not meet one of the other eligibility classifications, and have an unborn child or a child under age 19 in the household
AB/AD with Medicare	Recipients of Aid to Blind or Aid to Disabled with concurrent Medicare eligibility	Recipients of Aid to Blind or Aid to Disabled with concurrent Medicare eligibility
AB/AD without Medicare	Recipients of Aid to Blind or Aid to Disabled without concurrent Medicare eligibility	Recipients of Aid to Blind or Aid to Disabled without concurrent Medicare eligibility
OAA with Medicare	Recipients of Old Age Assistance with concurrent eligibility for Medicare Part A and/or B	Recipients of Old Age Assistance with concurrent eligibility for Medicare Part A and/or B
OAA without Medicare	Recipients of Old Age Assistance without concurrent Medicare eligibility	Recipients of Old Age Assistance without concurrent Medicare eligibility
SCF Children	Children covered by the State Office for Services to Children and Families	Children covered by the State Office for Services to Children and Families
CHIP Children under 1 year	Children under one year of age with family income under 170% FPL who do not meet one of the other eligibility classifications	Children under one year of age with family income under 185% FPL who do not meet one of the other eligibility classifications
CHIP Children 1 through 5 years	Children aged at least one but less than six years with family income under 170% FPL who do not meet one of the other eligibility classifications	Children aged at least one but less than six years with family income under 185% FPL who do not meet one of the other eligibility classifications
CHIP Children 6 through 18 years	Children aged at least six but less than nineteen years with family income under 170% FPL who do not meet one of the other eligibility classifications	Children aged at least six but less than nineteen years with family income under 185% FPL who do not meet one of the other eligibility classifications
CAWEM (Citizen-Alien Waived Emergency Medical)	Individuals who meet criteria for one of the above eligibility categories except for US citizenship or residency requirements	Individuals who meet criteria for one of the above eligibility categories except for US citizenship or residency requirements

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION
Expected Distribution of Population to be Covered by the Demonstration Project

	Expected Average Program Distribution
Temporary Assistance to Needy Families (Adults Only)	6.8%
General Assistance	0.7%
Poverty Level Medical Adults	1.8%
PLM, TANF, and CHIP Children < 1	4.7%
PLM, TANF, and CHIP Children 1 - 5	14.4%
PLM, TANF, and CHIP Children 6 - 18	22.7%
OHP Families	9.4%
OHP Adults & Couples	14.7%
Aid to the Blind/Aid to the Disabled with Medicare	4.1%
Aid to the Blind/Aid to the Disabled without Medicare	7.3%
Old Age Assistance with Medicare	6.2%
Old Age Assistance without Medicare	0.3%
SCF Children	2.9%
CAWEM (Citizen-Alien Waived Emergency Medical)	3.9%
TOTAL	100.0%

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Adjusted Encounter Utilization Rates by Eligibility Category Through Line 557* of the Prioritized List

Adjusted for changes in utilization, benefits, and eligibility

CATEGORY OF SERVICE	TYPE OF UNITS	TANF UNITS/1000	GA UNITS/1000	PLMA UNITS/1000	CHILDREN 00-01 UNITS/1000	CHILDREN 01-05 UNITS/1000	CHILDREN 06-18 UNITS/1000	OHPFAM UNITS/1000
PHYSICAL HEALTH								
ADMINISTRATIVE EXAMS	Claims							
ANESTHESIA	Claims	172.41	272.34	667.36	76.44	66.79	35.50	88.57
EXCEPT NEEDS CARE COORDINATION	Cases							
FP - IP HOSP	Admits							
FP - OP HOSP	Claims	14.16	4.51	9.08	0.08	0.03	2.59	10.73
FP - PHYS	Service	217.07	22.45	251.68	0.19	0.17	32.57	122.13
HYSTERECTOMY - ANESTHESIA	Claims	2.84	1.07	0.63				2.85
HYSTERECTOMY - IP HOSP	Admits	6.06	3.49	0.28	0.04			5.26
HYSTERECTOMY - OP HOSP	Claims	0.43		0.18	0.04		0.02	0.84
HYSTERECTOMY - PHYS	Service	17.58	8.22	1.29			0.01	15.76
IP HOSP - ACUTE DETOX	Admits	4.32	32.36	0.74			0.23	3.37
IP HOSP - MATERNITY	Admits	136.98	5.64	1,258.61			5.97	10.63
IP HOSP - MEDICAL/SURGICAL	Admits	64.70	332.37	26.15	96.57	21.98	14.20	49.67
IP HOSP - NEWBORN	Admits				627.87	0.01	0.01	
LAB & RAD - DIAGNOSTIC X-RAY	Service	1,693.07	3,737.36	3,161.92	999.17	319.41	476.45	1,259.94
LAB & RAD - LAB	Service	4,888.03	7,019.03	11,020.90	946.38	864.30	1,059.33	3,675.95
LAB & RAD - THERAPEUTIC X-RAY	Service	20.32	288.46	0.74	1.57	1.27	0.76	35.66
OP ER - SOMATIC MH	Claims	29.74	96.04	8.80	0.44	0.57	5.67	16.27
OP HOSP - BASIC	Claims	1,579.79	4,815.12	1,093.11	1,238.35	653.89	414.70	1,185.19
OP HOSP - EMERGENCY ROOM	Claims	798.34	1,177.32	366.43	814.17	468.51	279.59	465.14
OP HOSP - LAB & RAD	Claims	2,968.37	7,175.85	2,522.12	1,293.36	593.87	674.33	2,349.76
OP HOSP - MATERNITY	Claims	449.75	54.38	5,096.11	0.19	0.27	24.00	150.40
OP HOSP - SOMATIC MH	Claims	98.18	408.16	19.62	2.63	16.84	26.77	62.46
OTH MED - DME	Claims	166.18	897.28	138.07	237.90	57.96	34.85	112.54
OTH MED - HHC/PDN	Service	1,599.05	4,558.62	787.43	761.86	554.71	468.80	1,297.20
OTH MED - HOSPICE	Claims	1.17	162.02	0.36	6.55	0.80		9.83
OTH MED - MATERNITY MGT	Cases	4.77	0.21	51.88	0.26	0.01	0.37	0.85
OTH MED - SUPPLIES	Claims	155.23	743.63	95.05	166.94	69.29	75.04	137.50
PHYS CONSULTATION, IP & ER VISITS	Service	937.23	2,654.89	1,252.37	1,923.23	387.74	264.26	618.39
PHYS HOME OR LONG-TERM CARE VISITS	Service	1.22	85.40	5.68	3.82	1.79	1.26	1.53
PHYS MATERNITY	Cases	241.23	11.29	2,028.03	2.39	0.52	11.05	42.53
PHYS NEWBORN	Cases	5.61	7.25	29.35	547.89	3.66	2.37	2.35
PHYS OFFICE VISITS	Service	4,024.06	6,651.84	1,812.62	9,108.69	3,514.64	1,995.08	3,531.43
PHYS OTHER	Service	2,874.10	13,778.38	1,687.02	10,879.20	2,518.45	1,114.55	2,331.31
PHYS SOMATIC MH	Service	575.92	1,483.73	105.98	14.47	118.04	222.62	402.25
POST - HOSP EXTENDED CARE	Days	4.29	34.28	15.21	3.46	0.13	0.74	1.15

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Adjusted Encounter Utilization Rates by Eligibility Category Through Line 557* of the Prioritized List

Adjusted for changes in utilization, benefits, and eligibility

CATEGORY OF SERVICE	TYPE OF UNITS	TANF UNITS/1000	GA UNITS/1000	PLMA UNITS/1000	CHILDREN 00-01 UNITS/1000	CHILDREN 01-05 UNITS/1000	CHILDREN 06-18 UNITS/1000	OHPFAM UNITS/1000
PRES DRUGS - BASIC	Prescriptions	12,332.59	38,120.54	9,306.54	5,544.61	3,675.78	2,984.61	10,040.07
PRES DRUGS - FP	Prescriptions	419.57	70.19	384.46	1.25	1.56	73.36	374.02
PRES DRUGS - MH/CD	Prescriptions							
PRES DRUGS - NEURONTIN	Prescriptions	123.72	938.22	5.69		0.32	3.95	66.33
PRES DRUGS - OP HOSP BASIC	Claims	597.33	987.89	398.49	356.82	246.21	149.21	372.16
PRES DRUGS - OP HOSP FP	Claims							
PRES DRUGS - OP HOSP MH/CD	Claims	16.45	62.25	4.01	0.07	0.27	2.04	9.14
PRES DRUGS - TOBACCO CESSATION	Claims	144.17	329.78	45.09	0.29	0.45	4.72	118.46
SCHOOL-BASED HEALTH SERVICES	Service							
STERILIZATION - ANESTHESIA FEMALE	Claims	20.14	0.21	80.37			0.08	7.14
STERILIZATION - ANESTHESIA MALE	Claims	0.03					0.01	0.04
STERILIZATION - IP HOSP FEMALE	Admits	13.09	0.22	78.82			0.03	1.23
STERILIZATION - IP HOSP MALE	Admits							
STERILIZATION - OP HOSP FEMALE	Claims	730.37	73.33	5,081.70	1.58	0.46	48.42	169.18
STERILIZATION - OP HOSP MALE	Claims	0.61	0.86	0.91	0.19	0.14	0.09	1.36
STERILIZATION - PHY FEMALE	Service	29.41	0.23	137.03			0.07	7.18
STERILIZATION - PHY MALE	Service	1.60	0.43				0.01	5.80
SURGERY	Cases	700.15	1,455.28	1,053.67	413.40	170.85	200.57	621.11
TARGETED CASE MAN - BABIES FIRST	Cases							
TARGETED CASE MAN - HIV	Cases							
THERAPEUTIC ABORTION - IP HOSP	Admits							
THERAPEUTIC ABORTION - OP HOSP	Claims							
THERAPEUTIC ABORTION - PHYS	Service							
TOBACCO CES-IP HSP	Admits	21.62	38.62	47.67	0.04	0.03	0.85	7.95
TOBACCO CES-OP HSP	Claims	265.61	418.50	102.35	0.49	0.14	16.48	152.98
TOBACCO CES-PHYS	Service	64.11	82.56	20.99	0.11	0.16	6.20	46.12
TRANSPORTATION - AMBULANCE	Claims	112.70	497.84	125.46	82.02	30.06	26.15	60.42
TRANSPORTATION - OTHER	Claims							
VISION CARE - EXAMS & THERAPY	Service	290.12	421.48	258.20	27.58	72.33	276.85	361.59
VISION CARE - MATERIALS & FITTING	Service	833.23	1,098.56	728.66	6.60	85.74	651.94	980.90
CHEMICAL DEPENDENCY								
CD SERVICES - ALTERNATIVE TO DETOX	Claims	2.72	18.27	0.63			0.04	3.05
CD SERVICES - METHADONE	Service	4,270.38	25,643.70	645.78		0.55	19.47	3,236.59
CD SERVICES - OP	Service	12,465.32	19,984.01	4,409.88	0.18	2.48	1,079.41	5,686.27

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

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Adjusted for changes in utilization, benefits, and eligibility

CATEGORY OF SERVICE	TYPE OF UNITS	TANF UNITS/1000	GA UNITS/1000	PLMA UNITS/1000	CHILDREN 00-01 UNITS/1000	CHILDREN 01-05 UNITS/1000	CHILDREN 06-18 UNITS/1000	OHPFAM UNITS/1000
DENTAL								
DENTAL - ADJUNCTIVE GENERAL	Service	88.73	82.33	54.36	0.20	38.78	29.17	77.53
DENTAL - ANESTHESIA SURGICAL	Claims	87.37	63.74	26.21	1.02	105.56	90.53	71.37
DENTAL - DIAGNOSTIC	Service	1,785.84	1,650.76	1,337.34	12.78	1,030.07	1,732.37	2,049.96
DENTAL - ENDODONTICS	Service	103.03	84.40	67.34	0.10	120.96	79.42	112.81
DENTAL - I/P FIXED	Service	2.27	7.51	0.82			0.08	2.99
DENTAL - MAXILLOFACIAL PROS	Service	0.47	0.75	0.07		0.01	0.02	0.64
DENTAL - ORAL SURGERY	Service	546.78	682.92	188.08	1.25	102.76	198.58	503.24
DENTAL - ORTHODONTICS	Service	0.07		0.07		0.09	0.58	0.05
DENTAL - PERIODONTICS	Service	232.82	258.77	101.96	0.10	0.44	12.64	299.97
DENTAL - PREVENTIVE	Service	312.30	312.01	330.09	6.19	395.21	1,067.74	437.68
DENTAL - PROS REMOVABLE	Service	89.22	247.38	8.36		0.02	1.05	87.83
DENTAL - RESTORATIVE	Service	867.45	786.80	545.85	2.20	682.34	924.39	1,093.03
DENTAL - TOBACCO CES	Service	7.13	5.25	3.65		0.02	1.42	7.83
MENTAL HEALTH								
MH SERVICES ACUTE INPATIENT	Days	70.29	772.71	15.34		1.29	37.86	43.12
MH SERVICES ASSESS & EVAL	Service	1,111.08	2,931.66	434.34	6.11	224.61	661.65	573.47
MH SERVICES CASE MANAGEMENT	Service	331.09	7,337.89	70.72	0.62	97.10	385.80	137.91
MH SERVICES CONSULTATION	Service	92.99	617.45	21.59	0.59	43.35	155.30	27.61
MH SERVICES ANCILLARY SERVICES	Service	21.69	39.59	1.04		0.41	5.19	3.50
MH SERVICES MED MANAGEMENT	Service	563.66	4,520.30	55.98	0.03	15.37	152.01	227.02
MH SERVICES ALTERNATIVE TO IP	Service	179.99	4,962.28	3.04			9.10	141.14
MH SERVICES FAMILY SUPPORT	Service	33.64	382.75	0.09	1.79	39.98	206.53	2.36
MH SERVICES OP THERAPY	Service	5,325.40	23,140.49	1,313.02	8.66	858.38	3,487.73	2,189.72
MH SERVICES OTHER OP	Service	3.46	19.01	0.78		0.09	1.61	2.43
MH SERVICES PHYS IP	Service	12.17	136.79	8.79		0.41	6.23	8.57
MH SERVICES PHYS OP	Service	267.18	1,626.44	68.03	0.11	86.72	101.48	115.27
MH SERVICES SUPPORT DAY PROGRAM	Service	527.30	31,143.07	69.43	1.10	745.72	677.33	227.15

* Includes Lines 558, 559, 562, 564, 576, 624, and portions of Lines 615, 642, and 721. Inclusion of these lines equates to coverage through Line 566 of the Prioritized List as configured during the 2001-2003 Biennium.

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Adjusted Encounter Utilization Rates by Eligibility Category Through Line 557* of the Prioritized List

Adjusted for changes in utilization, benefits, and eligibility

CATEGORY OF SERVICE	TYPE OF UNITS	OHPAC UNITS/1000	ABAD-MED UNITS/1000	ABAD UNITS/1000	OAA-MED UNITS/1000	OAA UNITS/1000	SCF UNITS/1000	CAWEM UNITS/1000
PHYSICAL HEALTH								
ADMINISTRATIVE EXAMS	Claims							
ANESTHESIA	Claims	132.37	166.32	167.08	179.06	197.64	51.90	
EXCEPT NEEDS CARE COORDINATION	Cases							
FP - IP HOSP	Admits							
FP - OP HOSP	Claims	3.51	0.87	6.51			7.22	
FP - PHYS	Service	35.20	27.96	46.14	0.17		27.10	
HYSTERECTOMY - ANESTHESIA	Claims	1.77	1.03	1.11	0.56			
HYSTERECTOMY - IP HOSP	Admits	4.12	2.52	2.61	1.24	0.65		
HYSTERECTOMY - OP HOSP	Claims	0.55	0.12	0.07	0.23			
HYSTERECTOMY - PHYS	Service	11.47	4.51	7.47	2.04	3.53		
IP HOSP - ACUTE DETOX	Admits	13.88	3.75	5.62	0.81	0.66		
IP HOSP - MATERNITY	Admits	1.98	3.00	6.92	0.03		2.91	
IP HOSP - MEDICAL/SURGICAL	Admits	105.43	221.98	204.33	363.50	221.93	15.87	
IP HOSP - NEWBORN	Admits			0.14			1.83	
LAB & RAD - DIAGNOSTIC X-RAY	Service	1,894.54	2,209.86	2,385.59	2,937.91	3,497.07	457.07	
LAB & RAD - LAB	Service	4,473.66	3,409.72	4,917.22	3,267.35	4,747.30	1,485.17	
LAB & RAD - THERAPEUTIC X-RAY	Service	82.71	72.04	80.42	118.11	79.28	0.07	
OP ER - SOMATIC MH	Claims	32.59	55.85	61.35	12.14	7.66	13.56	
OP HOSP - BASIC	Claims	1,905.39	3,003.41	2,835.66	2,491.56	2,776.08	630.20	
OP HOSP - EMERGENCY ROOM	Claims	646.62	649.14	744.98	428.43	330.84	225.60	
OP HOSP - LAB & RAD	Claims	3,423.33	3,690.98	4,710.32	4,647.79	5,195.01	793.89	
OP HOSP - MATERNITY	Claims	64.38	13.04	41.10	0.13		33.21	
OP HOSP - SOMATIC MH	Claims	115.79	202.96	293.87	111.13	61.96	171.11	
OTH MED - DME	Claims	203.14	1,539.77	1,289.68	1,833.10	1,264.26	77.74	
OTH MED - HHC/PDN	Service	1,869.44	3,477.83	3,564.74	3,172.44	2,762.90	507.90	
OTH MED - HOSPICE	Claims	28.81	76.93	260.64	96.78	507.51	3.85	
OTH MED - MATERNITY MGT	Cases	0.14		0.35			0.14	
OTH MED - SUPPLIES	Claims	252.94	2,703.05	1,849.09	2,719.02	1,862.04	164.67	
PHYS CONSULTATION, IP & ER VISITS	Service	1,075.32	2,370.11	1,934.54	2,516.11	3,093.96	349.23	
PHYS HOME OR LONG-TERM CARE VISITS	Service	7.16	130.26	60.78	584.30	419.78	13.10	
PHYS MATERNITY	Cases	14.06	6.27	15.64	0.46	1.61	6.59	
PHYS NEWBORN	Cases	3.04	3.83	5.84	4.22	5.28	11.37	
PHYS OFFICE VISITS	Service	4,135.91	5,151.77	5,145.60	4,966.89	5,135.20	2,549.07	
PHYS OTHER	Service	4,473.43	11,814.74	10,894.94	16,745.39	13,971.79	3,353.20	
PHYS SOMATIC MH	Service	551.41	4,087.76	2,499.10	3,627.23	2,933.23	1,188.02	
POST - HOSP EXTENDED CARE	Days	5.13	21.42	40.25	24.93	24.60	0.07	

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

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CATEGORY OF SERVICE	TYPE OF UNITS	OHPAC UNITS/1000	ABAD-MED UNITS/1000	ABAD UNITS/1000	OAA-MED UNITS/1000	OAA UNITS/1000	SCF UNITS/1000	CAWEM UNITS/1000
PRES DRUGS - BASIC	Prescriptions	16,765.44	41,493.08	32,128.30	47,095.11	26,749.15	6,171.63	
PRES DRUGS - FP	Prescriptions	151.21	218.40	145.61	3.54	9.15	97.40	
PRES DRUGS - MH/CD	Prescriptions							
PRES DRUGS - NEURONTIN	Prescriptions	171.24	633.23	442.82	261.77	69.40	25.52	
PRES DRUGS - OP HOSP BASIC	Claims	520.37	614.96	691.42	472.41	445.24	118.77	
PRES DRUGS - OP HOSP FP	Claims							
PRES DRUGS - OP HOSP MH/CD	Claims	28.39	24.91	28.98	8.44	10.77	3.54	
PRES DRUGS - TOBACCO CESSATION	Claims	195.50	209.73	164.92	36.69	18.27	5.62	
SCHOOL-BASED HEALTH SERVICES	Service							
STERILIZATION - ANESTHESIA FEMALE	Claims	1.13	0.82	1.75				
STERILIZATION - ANESTHESIA MALE	Claims							
STERILIZATION - IP HOSP FEMALE	Admits	0.08	0.25	0.54				
STERILIZATION - IP HOSP MALE	Admits							
STERILIZATION - OP HOSP FEMALE	Claims	74.05	25.96	76.84	0.40		17.63	
STERILIZATION - OP HOSP MALE	Claims	0.51	0.04	0.23				
STERILIZATION - PHY FEMALE	Service	1.14	0.66	1.79				
STERILIZATION - PHY MALE	Service	0.84	0.41	0.31				
SURGERY	Cases	864.62	924.57	1,126.71	1,086.48	971.37	235.06	
TARGETED CASE MAN - BABIES FIRST	Cases							
TARGETED CASE MAN - HIV	Cases							
THERAPEUTIC ABORTION - IP HOSP	Admits							
THERAPEUTIC ABORTION - OP HOSP	Claims							
THERAPEUTIC ABORTION - PHYS	Service							
TOBACCO CES-IP HSP	Admits	17.27	13.54	14.60	7.91	5.21	0.22	
TOBACCO CES-OP HSP	Claims	269.50	161.54	228.97	68.72	85.84	7.73	
TOBACCO CES-PHYS	Service	65.85	49.87	40.05	12.21	3.92	7.10	
TRANSPORTATION - AMBULANCE	Claims	154.14	390.77	359.97	597.09	625.63	34.39	
TRANSPORTATION - OTHER	Claims							
VISION CARE - EXAMS & THERAPY	Service	443.66	389.46	341.18	496.78	498.37	269.02	
VISION CARE - MATERIALS & FITTING	Service	1,173.62	872.15	846.72	839.57	868.68	621.80	
CHEMICAL DEPENDENCY								
CD SERVICES - ALTERNATIVE TO DETOX	Claims	16.78	0.65	3.46			0.22	
CD SERVICES - METHADONE	Service	12,041.16	2,485.05	5,919.68	128.90	33.09	2.89	
CD SERVICES - OP	Service	16,425.21	4,089.81	4,034.42	88.70	3.82	4,130.30	

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DENTAL								
DENTAL - ADJUNCTIVE GENERAL	Service	80.25	88.97	66.09	82.56	78.81	28.19	
DENTAL - ANESTHESIA SURGICAL	Claims	71.15	42.00	49.37	7.48	41.21	90.60	
DENTAL - DIAGNOSTIC	Service	2,034.95	1,370.62	1,250.18	705.49	1,244.14	1,688.24	
DENTAL - ENDODONTICS	Service	102.93	50.93	53.68	17.96	51.94	69.26	
DENTAL - I/P FIXED	Service	6.27	6.69	4.04	13.85	7.76		
DENTAL - MAXILLOFACIAL PROS	Service	1.55	1.22	0.76	1.37			
DENTAL - ORAL SURGERY	Service	769.78	384.97	356.73	231.08	473.68	148.12	
DENTAL - ORTHODONTICS	Service	0.01	0.03	0.33			0.65	
DENTAL - PERIODONTICS	Service	316.68	231.09	166.24	77.09	142.56	11.46	
DENTAL - PREVENTIVE	Service	415.75	394.86	355.95	165.02	248.80	1,073.10	
DENTAL - PROS REMOVABLE	Service	202.73	157.99	135.72	230.15	398.24	0.82	
DENTAL - RESTORATIVE	Service	1,023.73	700.04	616.41	261.41	388.57	930.72	
DENTAL - TOBACCO CES	Service	8.29	2.95	3.18	0.63	0.60	0.94	
MENTAL HEALTH								
MH SERVICES ACUTE INPATIENT	Days	159.17	430.61	498.92	71.30	11.95	225.45	
MH SERVICES ASSESS & EVAL	Service	975.08	1,008.05	1,180.58	191.13	193.11	2,426.35	
MH SERVICES CASE MANAGEMENT	Service	552.82	4,669.57	4,099.31	485.26	241.99	3,067.20	
MH SERVICES CONSULTATION	Service	78.55	361.65	401.47	98.15	46.35	1,525.35	
MH SERVICES ANCILLARY SERVICES	Service	3.97	27.96	71.28	14.38	99.67	21.74	
MH SERVICES MED MANAGEMENT	Service	604.99	3,155.04	2,632.90	280.39	333.25	1,226.88	
MH SERVICES ALTERNATIVE TO IP	Service	832.48	3,379.42	2,222.23	22.95		290.33	
MH SERVICES FAMILY SUPPORT	Service	3.60	128.28	1,096.32	11.84		3,445.50	
MH SERVICES OP THERAPY	Service	4,151.23	7,492.16	7,878.11	675.56	394.20	23,892.01	
MH SERVICES OTHER OP	Service	10.49	21.85	12.60	8.05		10.24	
MH SERVICES PHYS IP	Service	23.69	84.38	96.24	19.42		42.65	
MH SERVICES PHYS OP	Service	304.99	706.69	697.86	115.95	228.45	1,011.84	
MH SERVICES SUPPORT DAY PROGRAM	Service	1,580.82	35,880.10	25,940.67	4,853.56	4,206.20	5,945.78	

* Includes Lines 558, 559, 562, 564, 576, 624, and portions of Lines 615, 642, and 721. Inclusion of these lines equates to coverage through Line 566 of the Prioritized List as configured during the 2001-2003 Biennium.

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Adjusted Fee For Service Utilization Rates by Eligibility Category Through Line 557* of the Prioritized List
 Adjusted for changes in utilization, benefits, and eligibility

CATEGORY OF SERVICE	TYPE OF UNITS	TANF UNITS/1000	GA UNITS/1000	PLMA UNITS/1000	CHILDREN 00-01 UNITS/1000	CHILDREN 01-05 UNITS/1000	CHILDREN 06-18 UNITS/1000	OHPFAM UNITS/1000
PHYSICAL HEALTH								
ADMINISTRATIVE EXAMS	Claims	78.05	1,225.96	15.37	2.26	2.33	4.74	28.12
ANESTHESIA	Claims	89.85	274.44	302.41	56.42	36.68	24.87	91.91
EXCEPT NEEDS CARE COORDINATION	Cases							
FP - IP HOSP	Admits							
FP - OP HOSP	Claims	40.77	5.58	51.88			6.00	21.70
FP - PHYS	Service	1,746.28	199.39	1,718.36	0.81	0.47	621.13	1,145.93
HYSTERECTOMY - ANESTHESIA	Claims	3.10		0.53				3.09
HYSTERECTOMY - IP HOSP	Admits	6.67	1.40	0.52			0.02	5.95
HYSTERECTOMY - OP HOSP	Claims							
HYSTERECTOMY - PHYS	Service	9.68	2.11	1.58			0.02	9.23
IP HOSP - ACUTE DETOX	Admits	2.52	11.93	0.52			0.42	2.69
IP HOSP - MATERNITY	Admits	102.65	2.81	910.77			5.08	54.53
IP HOSP - MEDICAL/SURGICAL	Admits	62.33	432.46	16.02	99.59	26.32	18.81	85.01
IP HOSP - NEWBORN	Admits	0.07		0.17	1,402.28	0.25	0.04	0.08
LAB & RAD - DIAGNOSTIC X-RAY	Service	1,403.34	4,835.14	2,676.47	1,354.01	270.22	414.09	1,232.24
LAB & RAD - LAB	Service	2,739.30	4,440.76	7,747.46	540.13	369.10	525.39	1,911.43
LAB & RAD - THERAPEUTIC X-RAY	Service	18.96	438.35	1.22	0.20	0.96	2.07	27.28
OP ER - SOMATIC MH	Claims							
OP HOSP - BASIC	Claims	2,334.22	7,810.91	1,349.36	2,327.81	1,011.80	730.97	1,997.00
OP HOSP - EMERGENCY ROOM	Claims	1,083.11	1,478.59	514.78	920.37	558.91	376.12	759.49
OP HOSP - LAB & RAD	Claims	3,334.18	9,736.08	3,059.95	1,603.30	707.28	857.85	2,995.81
OP HOSP - MATERNITY	Claims	437.73	11.16	6,303.38	0.10	0.16	20.66	125.98
OP HOSP - SOMATIC MH	Claims	151.10	815.00	22.11	1.72	10.02	43.26	119.68
OTH MED - DME	Claims	117.16	1,298.41	74.92	273.04	78.98	33.67	84.63
OTH MED - HHC/PDN	Service	1,961.06	6,929.87	862.90	962.47	637.80	673.13	1,878.36
OTH MED - HOSPICE	Claims	4.11	550.73		0.71		1.51	8.69
OTH MED - MATERNITY MGT	Cases	124.92	5.58	945.62			7.70	13.98
OTH MED - SUPPLIES	Claims	163.15	1,578.75	135.97	198.69	59.76	74.64	186.23
PHYS CONSULTATION, IP & ER VISITS	Service	795.94	4,570.62	1,009.12	2,720.60	339.37	249.59	734.87
PHYS HOME OR LONG-TERM CARE VISITS	Service	10.86	209.93	108.95	43.76	1.22	0.91	4.15
PHYS MATERNITY	Cases	297.34	15.71	2,606.22	0.94	0.04	16.31	108.45
PHYS NEWBORN	Cases	2.07	12.64	4.38	978.65	3.06	1.73	1.59
PHYS OFFICE VISITS	Service	3,403.65	6,385.52	1,441.78	8,417.36	2,505.91	1,541.44	2,673.69
PHYS OTHER	Service	4,684.88	59,101.35	1,922.26	7,390.48	1,581.57	891.91	3,033.52
PHYS SOMATIC MH	Service	727.06	2,029.04	267.48	170.98	7,286.07	11,331.35	375.61
POST - HOSP EXTENDED CARE	Days		2.11			0.34		0.41

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Adjusted Fee For Service Utilization Rates by Eligibility Category Through Line 557* of the Prioritized List
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CATEGORY OF SERVICE	TYPE OF UNITS	TANF UNITS/1000	GA UNITS/1000	PLMA UNITS/1000	CHILDREN 00-01 UNITS/1000	CHILDREN 01-05 UNITS/1000	CHILDREN 06-18 UNITS/1000	OHPFAM UNITS/1000
PRES DRUGS - BASIC	Prescriptions	7,830.37	25,256.25	5,025.36	3,075.14	2,218.12	1,993.03	6,086.76
PRES DRUGS - FP	Prescriptions	675.25	237.35	538.65	0.48	0.27	122.25	672.90
PRES DRUGS - MH/CD	Prescriptions	2,606.62	11,261.91	549.66	8.94	32.13	260.27	1,821.70
PRES DRUGS - NEURONTIN	Prescriptions	106.45	788.08	2.14		0.59	3.86	56.52
PRES DRUGS - OP HOSP BASIC	Claims	788.43	1,504.27	416.48	478.90	323.42	215.99	607.60
PRES DRUGS - OP HOSP FP	Claims							
PRES DRUGS - OP HOSP MH/CD	Claims	39.50	301.69	6.92	0.20	0.40	5.23	27.59
PRES DRUGS - TOBACCO CESSATION	Claims	102.28	207.41	22.11		0.06	3.92	70.89
SCHOOL-BASED HEALTH SERVICES	Service	6.42	60.06	9.48	212.50	927.01	1,088.46	0.25
STERILIZATION - ANESTHESIA FEMALE	Claims	13.53		46.07			0.04	7.44
STERILIZATION - ANESTHESIA MALE	Claims				0.10			0.04
STERILIZATION - IP HOSP FEMALE	Admits	13.71		77.12			0.04	4.69
STERILIZATION - IP HOSP MALE	Admits							
STERILIZATION - OP HOSP FEMALE	Claims	817.27	41.17	6,408.71			73.08	279.28
STERILIZATION - OP HOSP MALE	Claims	0.37	0.70					1.37
STERILIZATION - PHY FEMALE	Service	19.51		86.18			0.09	9.31
STERILIZATION - PHY MALE	Service	1.11	1.40					4.80
SURGERY	Cases	520.25	1,698.27	928.03	580.10	128.68	149.01	498.84
TARGETED CASE MAN - BABIES FIRST	Cases				257.92	42.79		
TARGETED CASE MAN - HIV	Cases	0.04	1.77					0.04
THERAPEUTIC ABORTION - IP HOSP	Admits	0.12		1.12			0.01	0.10
THERAPEUTIC ABORTION - OP HOSP	Claims	25.46	0.64	109.98	0.03		2.70	10.38
THERAPEUTIC ABORTION - PHYS	Service	77.88	6.97	340.93	0.03	0.02	7.46	37.00
TOBACCO CES-IP HSP	Admits	22.46	58.97	41.78			1.35	14.83
TOBACCO CES-OP HSP	Claims	484.81	646.84	299.26	0.50	0.59	39.11	372.65
TOBACCO CES-PHYS	Service	22.25	40.02	5.08	0.10	0.06	2.38	28.30
TRANSPORTATION - AMBULANCE	Claims	320.01	2,576.72	213.32	189.60	54.73	67.38	195.54
TRANSPORTATION - OTHER	Claims	1,751.03	22,600.77	344.80	93.86	53.42	123.52	845.45
VISION CARE - EXAMS & THERAPY	Service	298.26	456.50	160.91	36.74	61.59	207.23	244.65
VISION CARE - MATERIALS & FITTING	Service	1,131.09	1,497.94	694.32	12.92	104.47	739.57	978.65
CHEMICAL DEPENDENCY								
CD SERVICES - ALTERNATIVE TO DETOX	Claims							
CD SERVICES - METHADONE	Service	2,196.82	10,255.41	509.12			3.31	2,024.59
CD SERVICES - OP	Service	14,916.20	15,576.81	2,337.03		0.37	1,180.85	6,827.66

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Adjusted Fee For Service Utilization Rates by Eligibility Category Through Line 557* of the Prioritized List

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CATEGORY OF SERVICE	TYPE OF UNITS	TANF UNITS/1000	GA UNITS/1000	PLMA UNITS/1000	CHILDREN 00-01 UNITS/1000	CHILDREN 01-05 UNITS/1000	CHILDREN 06-18 UNITS/1000	OHPFAM UNITS/1000
DENTAL								
DENTAL - ADJUNCTIVE GENERAL	Service	16.99	7.27	7.60		9.12	7.34	12.99
DENTAL - ANESTHESIA SURGICAL	Claims	7.16	2.91	1.58		9.06	8.59	7.45
DENTAL - DIAGNOSTIC	Service	352.59	241.21	120.35	0.35	135.80	261.52	299.64
DENTAL - ENDODONTICS	Service	22.47	14.53	6.97		16.76	11.97	15.12
DENTAL - I/P FIXED	Service							0.07
DENTAL - MAXILLOFACIAL PROS	Service						0.04	0.07
DENTAL - ORAL SURGERY	Service	95.06	90.09	21.22		13.73	29.09	72.62
DENTAL - ORTHODONTICS	Service	0.14						
DENTAL - PERIODONTICS	Service	31.03	68.29	6.33	0.18		1.98	30.24
DENTAL - PREVENTIVE	Service	28.51	31.97	16.79		45.32	116.75	35.07
DENTAL - PROS REMOVABLE	Service	3.51	21.80			0.11	0.14	5.82
DENTAL - RESTORATIVE	Service	118.65	97.35	32.62	0.18	76.20	102.98	90.93
DENTAL - TOBACCO CES	Service	1.12					0.18	0.43
MENTAL HEALTH								
MH SERVICES ACUTE INPATIENT	Days	82.60	2,620.62	10.68	5.45	1.08	78.46	90.62
MH SERVICES ASSESS & EVAL	Service	1,079.63	3,788.52	198.28	4.14	151.06	464.01	435.34
MH SERVICES CASE MANAGEMENT	Service	168.87	8,731.76	38.51		48.11	223.90	113.73
MH SERVICES CONSULTATION	Service	57.53	605.69	10.93		25.18	83.68	19.22
MH SERVICES ANCILLARY SERVICES	Service	9.59	15.63	1.49		5.45	3.68	0.93
MH SERVICES MED MANAGEMENT	Service	241.85	2,573.22	23.85		8.64	81.43	158.82
MH SERVICES ALTERNATIVE TO IP	Service	3.02	156.31				1.53	1.29
MH SERVICES FAMILY SUPPORT	Service	0.53	1.95			0.54	1.71	
MH SERVICES OP THERAPY	Service	2,530.20	20,452.92	436.56		447.68	1,826.65	1,114.38
MH SERVICES OTHER OP	Service	1.61	263.44			1.52	3.05	0.99
MH SERVICES PHYS IP	Service	13.50	466.97	0.75		0.05	9.73	10.46
MH SERVICES PHYS OP	Service	2.84	23.45			0.05	0.51	0.99
MH SERVICES SUPPORT DAY PROGRAM	Service	233.50	57,411.98	51.43		416.41	734.15	295.50

* Includes Lines 558, 559, 562, 564, 576, 624, and portions of Lines 615, 642, and 721. Inclusion of these lines equates to coverage through Line 566 of the Prioritized List as configured during the 2001-2003 Biennium.

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

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PHYSICAL HEALTH								
ADMINISTRATIVE EXAMS	Claims	223.76	14.73	22.49	0.93	1.58	185.52	0.06
ANESTHESIA	Claims	169.35	171.32	134.68	80.78	226.92	34.54	60.73
EXCEPT NEEDS CARE COORDINATION	Cases							
FP - IP HOSP	Admits							
FP - OP HOSP	Claims	6.94	5.20	8.10	0.08		7.73	0.32
FP - PHYS	Service	789.55	113.84	230.43			205.71	2.61
HYSTERECTOMY - ANESTHESIA	Claims	2.69	1.39	1.63	0.43			0.22
HYSTERECTOMY - IP HOSP	Admits	5.08	2.62	2.56	0.74			0.47
HYSTERECTOMY - OP HOSP	Claims			0.06				
HYSTERECTOMY - PHYS	Service	8.72	5.84	4.37	1.01			0.38
IP HOSP - ACUTE DETOX	Admits	16.51	4.71	5.11	0.77		0.40	0.09
IP HOSP - MATERNITY	Admits	6.39	2.10	5.52			2.18	165.80
IP HOSP - MEDICAL/SURGICAL	Admits	252.33	225.15	230.50	191.92	353.45	24.07	30.59
IP HOSP - NEWBORN	Admits			1.45			11.89	0.28
LAB & RAD - DIAGNOSTIC X-RAY	Service	2,783.70	2,563.50	2,302.24	2,049.04	5,761.01	396.55	178.15
LAB & RAD - LAB	Service	2,899.94	1,254.63	3,346.66	680.90	3,088.28	633.87	47.65
LAB & RAD - THERAPEUTIC X-RAY	Service	123.28	98.36	109.05	78.41	538.32	1.98	3.01
OP ER - SOMATIC MH	Claims							
OP HOSP - BASIC	Claims	3,737.78	5,705.24	4,639.91	2,377.97	5,157.98	936.57	217.47
OP HOSP - EMERGENCY ROOM	Claims	1,313.38	895.39	955.95	349.42	641.99	257.44	141.08
OP HOSP - LAB & RAD	Claims	5,540.32	5,952.82	6,154.22	3,380.13	7,961.98	1,068.41	341.27
OP HOSP - MATERNITY	Claims	72.49	8.40	30.39	0.04	9.44	19.12	25.81
OP HOSP - SOMATIC MH	Claims	276.09	464.67	473.09	117.21	207.70	209.60	4.14
OTH MED - DME	Claims	195.50	1,539.72	1,591.83	1,237.51	1,288.90	152.16	0.16
OTH MED - HHC/PDN	Service	3,706.52	6,279.11	6,825.00	2,257.67	6,072.67	795.58	266.52
OTH MED - HOSPICE	Claims	73.36	5.11	519.57	46.71	654.80		
OTH MED - MATERNITY MGT	Cases	3.61	3.47	7.64			1.59	0.44
OTH MED - SUPPLIES	Claims	421.22	3,581.86	3,254.63	3,260.19	4,234.58	339.82	1.37
PHYS CONSULTATION, IP & ER VISITS	Service	2,049.13	1,960.31	2,176.59	1,342.85	6,038.49	351.23	184.25
PHYS HOME OR LONG-TERM CARE VISITS	Service	9.59	214.42	135.25	563.96	1,200.10	5.68	
PHYS MATERNITY	Cases	22.85	8.37	18.47	0.05		7.87	186.18
PHYS NEWBORN	Cases	3.56	5.93	6.58	3.15	19.00	17.74	0.32
PHYS OFFICE VISITS	Service	3,824.30	4,242.00	4,501.13	2,262.12	3,232.98	1,927.77	18.97
PHYS OTHER	Service	12,673.79	19,811.79	16,791.04	8,621.84	10,031.43	4,239.96	26.77
PHYS SOMATIC MH	Service	888.80	1,988.12	35,252.59	2,888.21	4,768.73	32,260.91	8.98
POST - HOSP EXTENDED CARE	Days	0.04	0.09	21.21	0.04			

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

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PRES DRUGS - BASIC	Prescriptions	10,022.23	36,085.35	22,445.51	45,577.90	70,164.47	3,903.13	28.01
PRES DRUGS - FP	Prescriptions	280.69	375.86	302.34	3.44	84.39	115.50	1.15
PRES DRUGS - MH/CD	Prescriptions	3,120.34	11,214.29	7,829.67	6,675.14	4,379.08	1,945.61	2.12
PRES DRUGS - NEURONTIN	Prescriptions	143.41	712.14	411.60	383.92	452.08	27.88	0.09
PRES DRUGS - OP HOSP BASIC	Claims	1,038.55	923.86	989.67	379.71	1,266.79	160.77	101.05
PRES DRUGS - OP HOSP FP	Claims							
PRES DRUGS - OP HOSP MH/CD	Claims	97.92	92.39	140.97	21.83	93.84	10.73	1.85
PRES DRUGS - TOBACCO CESSATION	Claims	123.12	135.42	104.14	35.11	43.64	3.64	
SCHOOL-BASED HEALTH SERVICES	Service	5.09	388.88	17,298.15			6,895.44	4.59
STERILIZATION - ANESTHESIA FEMALE	Claims	1.10	0.87	0.82				2.20
STERILIZATION - ANESTHESIA MALE	Claims			0.06				
STERILIZATION - IP HOSP FEMALE	Admits	0.31	0.35	0.46				7.08
STERILIZATION - IP HOSP MALE	Admits							
STERILIZATION - OP HOSP FEMALE	Claims	148.48	39.68	61.25			12.58	246.19
STERILIZATION - OP HOSP MALE	Claims	1.14	0.26	0.98				0.51
STERILIZATION - PHY FEMALE	Service	1.14	1.74	1.22				1.27
STERILIZATION - PHY MALE	Service	0.99	0.35	0.52				
SURGERY	Cases	934.84	787.54	1,078.53	489.53	1,095.54	201.94	35.06
TARGETED CASE MAN - BABIES FIRST	Cases		0.05	9.80			11.10	
TARGETED CASE MAN - HIV	Cases	0.10	1.02	0.70				
THERAPEUTIC ABORTION - IP HOSP	Admits	0.04	0.06					
THERAPEUTIC ABORTION - OP HOSP	Claims	6.67	0.80	2.75	0.30		0.66	0.25
THERAPEUTIC ABORTION - PHYS	Service	16.81	1.99	3.98	0.09		2.83	1.21
TOBACCO CES-IP HSP	Admits	48.76	15.54	16.74	4.38	9.47	0.69	1.17
TOBACCO CES-OP HSP	Claims	767.68	324.77	363.38	80.35	78.68	11.99	5.54
TOBACCO CES-PHYS	Service	36.20	15.52	11.42	1.55		3.59	
TRANSPORTATION - AMBULANCE	Claims	732.47	5,156.57	2,421.42	5,940.70	12,089.41	67.56	48.75
TRANSPORTATION - OTHER	Claims	4,443.46	8,580.70	6,043.87	5,193.11	4,720.47	1,169.90	0.19
VISION CARE - EXAMS & THERAPY	Service	372.26	404.17	356.09	359.97	424.99	195.70	0.41
VISION CARE - MATERIALS & FITTING	Service	1,386.43	1,093.79	1,126.88	724.18	1,262.39	709.97	0.09
CHEMICAL DEPENDENCY								
CD SERVICES - ALTERNATIVE TO DETOX	Claims							
CD SERVICES - METHADONE	Service	6,097.00	2,346.29	2,716.92	37.66		8.99	1.94
CD SERVICES - OP	Service	22,206.14	3,876.00	3,716.34	47.61		11,800.16	0.22

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

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DENTAL								
DENTAL - ADJUNCTIVE GENERAL	Service	11.83	9.07	28.46	8.60	17.55	6.29	
DENTAL - ANESTHESIA SURGICAL	Claims	7.08	2.45	11.43	0.64		11.83	
DENTAL - DIAGNOSTIC	Service	326.22	217.46	269.64	86.80	81.92	370.34	0.13
DENTAL - ENDODONTICS	Service	11.21	4.90	11.31	0.77		11.53	
DENTAL - I/P FIXED	Service	0.07						
DENTAL - MAXILLOFACIAL PROS	Service							
DENTAL - ORAL SURGERY	Service	99.07	43.88	66.23	20.42	5.85	29.34	
DENTAL - ORTHODONTICS	Service	0.07					0.15	
DENTAL - PERIODONTICS	Service	22.96	30.15	17.89	4.11		1.65	
DENTAL - PREVENTIVE	Service	36.71	36.04	88.97	36.59	5.85	229.33	0.03
DENTAL - PROS REMOVABLE	Service	8.80	26.72	12.55	29.40	17.55	0.15	
DENTAL - RESTORATIVE	Service	77.00	73.06	143.40	23.37		150.74	
DENTAL - TOBACCO CES	Service	0.83	0.74	0.50	0.13		0.15	
MENTAL HEALTH								
MH SERVICES ACUTE INPATIENT	Days	713.23	424.22	619.48	74.45	11.22	435.88	13.14
MH SERVICES ASSESS & EVAL	Service	1,432.79	938.18	1,193.46	131.63	268.41	2,366.83	1.43
MH SERVICES CASE MANAGEMENT	Service	607.62	3,818.36	2,427.30	198.01	33.55	1,678.95	2.86
MH SERVICES CONSULTATION	Service	64.43	375.27	386.97	70.19	139.80	1,032.20	0.19
MH SERVICES ANCILLARY SERVICES	Service	1.83	10.14	8.79	0.30		0.74	
MH SERVICES MED MANAGEMENT	Service	474.63	1,516.31	1,114.18	86.21	55.92	806.81	0.10
MH SERVICES ALTERNATIVE TO IP	Service	21.15	47.13	26.21	1.72		20.10	
MH SERVICES FAMILY SUPPORT	Service	0.63	7.16	10.74	0.07		17.68	
MH SERVICES OP THERAPY	Service	2,617.60	6,413.95	6,448.70	330.91	805.24	12,958.28	4.10
MH SERVICES OTHER OP	Service	0.80	60.56	12.21	3.89	33.65	51.00	
MH SERVICES PHYS IP	Service	52.45	592.74	105.49	99.60	178.94	92.50	1.08
MH SERVICES PHYS OP	Service	2.24	29.23	17.26	7.78	50.33	7.44	
MH SERVICES SUPPORT DAY PROGRAM	Service	1,633.59	34,027.54	24,732.62	1,558.00	307.56	16,153.50	

* Includes Lines 558, 559, 562, 564, 576, 624, and portions of Lines 615, 642, and 721. Inclusion of these lines equates to coverage through Line 566 of the Prioritized List as configured during the 2001-2003 Biennium.

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION
Cost-to-Charge Ratios by Category of Service

Exhibit 4

CATEGORY OF SERVICE	Members w/o Medicare	Members w/Medicare
PHYSICAL HEALTH		
ADMINISTRATIVE EXAMS	100%	100%
ANESTHESIA	35%	5%
EXCEPT NEEDS CARE COORDINATION	100%	100%
FP - IP HOSP	65%	65%
FP - OP HOSP	61%	13%
FP - PHYS	66%	64%
HYSTERECTOMY - ANESTHESIA	35%	2%
HYSTERECTOMY - IP HOSP	65%	1%
HYSTERECTOMY - OP HOSP	61%	61%
HYSTERECTOMY - PHYS	31%	0%
IP HOSP - ACUTE DETOX	65%	5%
IP HOSP - MATERNITY	65%	8%
IP HOSP - MEDICAL/SURGICAL	65%	3%
IP HOSP - NEWBORN	65%	65%
LAB & RAD - DIAGNOSTIC X-RAY	51%	5%
LAB & RAD - LAB	50%	12%
LAB & RAD - THERAPEUTIC X-RAY	39%	2%
OP ER - SOMATIC MH	61%	61%
OP HOSP - BASIC	61%	15%
OP HOSP - EMERGENCY ROOM	61%	16%
OP HOSP - LAB & RAD	61%	12%
OP HOSP - MATERNITY	61%	15%
OP HOSP - SOMATIC MH	61%	7%
OTH MED - DME	55%	17%
OTH MED - HHC/PDN	59%	8%
OTH MED - HOSPICE	59%	59%
OTH MED - MATERNITY MGT	100%	100%
OTH MED - SUPPLIES	55%	40%
PHYS CONSULTATION, IP & ER VISITS	48%	4%
PHYS HOME OR LONG-TERM CARE VISITS	80%	18%
PHYS MATERNITY	73%	28%
PHYS NEWBORN	73%	4%
PHYS OFFICE VISITS	73%	17%
PHYS OTHER	48%	24%
PHYS SOMATIC MH	66%	35%
POST - HOSP EXTENDED CARE	65%	65%
PRES DRUGS - BASIC	95%	95%
PRES DRUGS - FP	95%	95%
PRES DRUGS - MH/CD	100%	100%
PRES DRUGS - OP HOSP BASIC	61%	16%
PRES DRUGS - OP HOSP FP	61%	61%
PRES DRUGS - OP HOSP MH/CD	100%	100%
PRES DRUGS - TOBACCO CESSATION	95%	90%
SCHOOL-BASED HEALTH SERVICES	100%	100%
STERILIZATION - ANESTHESIA FEMALE	35%	19%
STERILIZATION - ANESTHESIA MALE	35%	35%
STERILIZATION - IP HOSP FEMALE	65%	0%
STERILIZATION - IP HOSP MALE	65%	65%
STERILIZATION - OP HOSP FEMALE	61%	15%
STERILIZATION - OP HOSP MALE	61%	57%
STERILIZATION - PHY FEMALE	26%	18%
STERILIZATION - PHY MALE	93%	93%
SURGERY	38%	9%
TARGETED CASE MAN - BABIES FIRST	100%	100%
TARGETED CASE MAN - HIV	100%	100%
THERAPEUTIC ABORTION - IP HOSP	100%	100%
THERAPEUTIC ABORTION - OP HOSP	100%	100%
THERAPEUTIC ABORTION - PHYS	100%	100%
TOBACCO CES-IP HSP	65%	2%
TOBACCO CES-OP HSP	61%	15%
TOBACCO CES-PHYS	65%	30%
TRANSPORTATION - AMBULANCE	71%	31%
TRANSPORTATION - OTHER	100%	100%
VISION CARE - EXAMS & THERAPY	94%	39%
VISION CARE - MATERIALS & FITTING	89%	83%

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Exhibit 4

Cost-to-Charge Ratios by Category of Service

CATEGORY OF SERVICE	Members w/o Medicare	Members w/Medicare
CHEMICAL DEPENDENCY		
CD SERVICES - ALTERNATIVE TO DETOX	100%	100%
CD SERVICES - METHADONE	100%	94%
CD SERVICES - OP	100%	100%
DENTAL		
DENTAL - ADJUNCTIVE GENERAL	100%	100%
DENTAL - ANESTHESIA SURGICAL	100%	100%
DENTAL - DIAGNOSTIC	100%	100%
DENTAL - ENDODONTICS	100%	100%
DENTAL - I/P FIXED	100%	100%
DENTAL - MAXILLOFACIAL PROS	100%	100%
DENTAL - ORAL SURGERY	100%	100%
DENTAL - ORTHODONTICS	100%	100%
DENTAL - PERIODONTICS	100%	100%
DENTAL - PREVENTIVE	100%	100%
DENTAL - PROS REMOVABLE	100%	100%
DENTAL - RESTORATIVE	100%	100%
DENTAL - TOBACCO CES	100%	100%
MENTAL HEALTH		
MH SERVICES ACUTE INPATIENT	68%	10%
MH SERVICES ASSESS & EVAL	105%	94%
MH SERVICES CASE MANAGEMENT	111%	111%
MH SERVICES CONSULTATION	116%	116%
MH SERVICES ANCILLARY SERVICES	130%	120%
MH SERVICES MED MANAGEMENT	108%	94%
MH SERVICES ALTERNATIVE TO IP	100%	79%
MH SERVICES FAMILY SUPPORT	112%	112%
MH SERVICES OP THERAPY	115%	105%
MH SERVICES OTHER OP	115%	73%
MH SERVICES PHYS IP	115%	57%
MH SERVICES PHYS OP	111%	40%
MH SERVICES SUPPORT DAY PROGRAM	113%	113%

* These services are based on Medicaid payment amounts.

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Calculation of Encounter Billed Charges/Unit

7/99 - 6/01 MMIS Data

Charges per Unit by Medicaid Eligibility Category

CATEGORY OF SERVICE	TYPE OF UNITS	TANF BILLED CHGS/UNIT	GA BILLED CHGS/UNIT	PLMA BILLED CHGS/UNIT	CHILDREN 00-01 BILLED CHGS/UNIT	CHILDREN 01-05 BILLED CHGS/UNIT	CHILDREN 06-18 BILLED CHGS/UNIT	OHPFAM BILLED CHGS/UNIT
PHYSICAL HEALTH								
ADMINISTRATIVE EXAMS	Claims							
ANESTHESIA	Claims	\$596.31	\$679.65	\$594.31	\$547.87	\$544.77	\$541.01	\$592.19
EXCEPT NEEDS CARE COORDINATION	Cases							
FP - IP HOSP	Admits							
FP - OP HOSP	Claims	\$61.59	\$88.61	\$56.14	\$171.29	\$171.29	\$46.19	\$67.52
FP - PHYS	Service	\$63.25	\$69.02	\$105.98	\$27.51	\$84.56	\$52.61	\$71.83
HYSTERECTOMY - ANESTHESIA	Claims	\$789.93	\$818.00	\$698.89				\$769.88
HYSTERECTOMY - IP HOSP	Admits	\$7,960.21	\$8,299.52	\$24,080.12	\$6,269.81			\$7,757.57
HYSTERECTOMY - OP HOSP	Claims	\$462.10		\$34.95	\$95.00		\$35.55	\$626.55
HYSTERECTOMY - PHYS	Service	\$1,225.21	\$1,182.47	\$1,242.97			\$1,962.00	\$1,231.62
IP HOSP - ACUTE DETOX	Admits	\$2,639.93	\$3,696.43	\$2,788.61			\$2,611.05	\$3,266.54
IP HOSP - MATERNITY	Admits	\$4,082.87	\$5,451.98	\$4,136.60			\$4,042.81	\$3,960.85
IP HOSP - MEDICAL/SURGICAL	Admits	\$9,401.54	\$12,644.09	\$6,028.92	\$8,652.14	\$7,122.85	\$9,191.07	\$9,543.51
IP HOSP - NEWBORN	Admits				\$3,591.00	\$1,260.10	\$1,050.69	
LAB & RAD - DIAGNOSTIC X-RAY	Service	\$112.20	\$99.74	\$151.48	\$62.26	\$67.10	\$78.24	\$109.43
LAB & RAD - LAB	Service	\$27.62	\$28.43	\$26.91	\$22.07	\$20.84	\$23.73	\$28.46
LAB & RAD - THERAPEUTIC X-RAY	Service	\$255.75	\$243.94	\$182.13	\$102.84	\$321.19	\$204.25	\$272.17
OP ER - SOMATIC MH	Claims	\$170.38	\$230.47	\$166.63	\$108.97	\$170.95	\$171.20	\$169.43
OP HOSP - BASIC	Claims	\$194.08	\$188.95	\$138.83	\$168.35	\$214.79	\$189.15	\$210.72
OP HOSP - EMERGENCY ROOM	Claims	\$176.76	\$220.63	\$167.97	\$151.59	\$145.18	\$152.03	\$176.87
OP HOSP - LAB & RAD	Claims	\$87.63	\$103.01	\$64.48	\$73.08	\$74.85	\$82.79	\$87.92
OP HOSP - MATERNITY	Claims	\$71.42	\$94.90	\$63.37	\$27.86	\$54.38	\$62.77	\$50.51
OP HOSP - SOMATIC MH	Claims	\$63.39	\$60.63	\$88.35	\$107.15	\$119.85	\$70.37	\$56.35
OTH MED - DME	Claims	\$119.96	\$158.28	\$51.26	\$100.95	\$76.18	\$102.78	\$127.91
OTH MED - HHC/PDN	Service	\$39.58	\$39.73	\$41.47	\$36.63	\$31.90	\$30.79	\$39.91
OTH MED - HOSPICE	Claims	\$112.26	\$111.23	\$95.59	\$110.14	\$34.56		\$106.47
OTH MED - MATERNITY MGT	Cases	\$154.82	\$214.90	\$143.30	\$91.38	\$20.13	\$268.16	\$97.88
OTH MED - SUPPLIES	Claims	\$44.81	\$72.98	\$90.86	\$59.91	\$62.46	\$48.71	\$42.57
PHYS CONSULTATION, IP & ER VISITS	Service	\$149.12	\$157.24	\$134.27	\$139.86	\$135.01	\$139.54	\$151.42
PHYS HOME OR LONG-TERM CARE VISITS	Service	\$91.52	\$90.26	\$92.45	\$113.95	\$82.81	\$82.98	\$105.32
PHYS MATERNITY	Cases	\$1,695.52	\$772.70	\$1,819.71	\$75.20	\$174.86	\$1,634.02	\$986.11
PHYS NEWBORN	Cases	\$201.59	\$151.50	\$223.31	\$455.67	\$266.67	\$285.38	\$170.47
PHYS OFFICE VISITS	Service	\$72.98	\$75.07	\$69.34	\$79.32	\$73.76	\$70.42	\$75.46
PHYS OTHER	Service	\$31.26	\$31.26	\$28.14	\$20.08	\$20.24	\$24.58	\$36.50
PHYS SOMATIC MH	Service	\$59.41	\$53.95	\$71.37	\$67.97	\$53.14	\$63.56	\$60.02
POST - HOSP EXTENDED CARE	Days	\$137.92	\$124.70	\$127.02	\$90.64	\$122.68	\$90.94	\$102.25

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Calculation of Encounter Billed Charges/Unit

7/99 - 6/01 MMIS Data

Charges per Unit by Medicaid Eligibility Category

CATEGORY OF SERVICE	TYPE OF UNITS	TANF BILLED CHGS/UNIT	GA BILLED CHGS/UNIT	PLMA BILLED CHGS/UNIT	CHILDREN 00-01 BILLED CHGS/UNIT	CHILDREN 01-05 BILLED CHGS/UNIT	CHILDREN 06-18 BILLED CHGS/UNIT	OHPFAM BILLED CHGS/UNIT
PRES DRUGS - BASIC	Prescriptions	\$25.19	\$35.46	\$15.54	\$10.62	\$13.60	\$22.54	\$23.39
PRES DRUGS - FP	Prescriptions	\$33.03	\$34.26	\$37.36	\$47.78	\$29.04	\$34.05	\$33.37
PRES DRUGS - MH/CD	Prescriptions							
PRES DRUGS - NEURONTIN	Prescriptions	\$106.99	\$113.13	\$67.67		\$99.54	\$93.08	\$102.94
PRES DRUGS - OP HOSP BASIC	Claims	\$72.70	\$106.80	\$57.07	\$96.38	\$47.61	\$60.85	\$100.10
PRES DRUGS - OP HOSP FP	Claims							
PRES DRUGS - OP HOSP MH/CD	Claims	\$33.90	\$48.17	\$40.22	\$10.86	\$58.39	\$37.16	\$36.78
PRES DRUGS - TOBACCO CESSATION	Claims	\$47.27	\$43.69	\$42.20	\$27.99	\$61.93	\$48.43	\$40.67
SCHOOL-BASED HEALTH SERVICES	Service							
STERILIZATION - ANESTHESIA FEMALE	Claims	\$560.96	\$400.13	\$541.63			\$576.68	\$547.36
STERILIZATION - ANESTHESIA MALE	Claims	\$720.00					\$180.00	\$441.00
STERILIZATION - IP HOSP FEMALE	Admits	\$3,913.13	\$7,324.28	\$3,879.91			\$1,671.48	\$4,078.91
STERILIZATION - IP HOSP MALE	Admits							
STERILIZATION - OP HOSP FEMALE	Claims	\$147.52	\$123.45	\$116.27	\$74.52	\$97.19	\$114.27	\$197.23
STERILIZATION - OP HOSP MALE	Claims	\$129.16	\$34.68	\$42.05	\$61.40	\$87.93	\$67.63	\$125.05
STERILIZATION - PHY FEMALE	Service	\$586.21	\$375.16	\$535.30			\$804.58	\$780.39
STERILIZATION - PHY MALE	Service	\$446.95	\$568.55				\$444.34	\$425.71
SURGERY	Cases	\$415.06	\$676.88	\$116.08	\$306.48	\$336.49	\$332.12	\$402.08
TARGETED CASE MAN - BABIES FIRST	Cases							
TARGETED CASE MAN - HIV	Cases							
THERAPEUTIC ABORTION - IP HOSP	Admits							
THERAPEUTIC ABORTION - OP HOSP	Claims							
THERAPEUTIC ABORTION - PHYS	Service							
TOBACCO CES-IP HSP	Admits	\$318.16	\$490.23	\$246.86	\$424.19	\$190.01	\$280.29	\$387.92
TOBACCO CES-OP HSP	Claims	\$9.72	\$10.86	\$8.45	\$27.52	\$2.72	\$7.72	\$10.67
TOBACCO CES-PHYS	Service	\$54.91	\$80.69	\$80.95	\$47.12	\$83.24	\$35.20	\$61.13
TRANSPORTATION - AMBULANCE	Claims	\$370.55	\$364.51	\$476.81	\$779.16	\$485.35	\$401.47	\$413.43
TRANSPORTATION - OTHER	Claims							
VISION CARE - EXAMS & THERAPY	Service	\$64.08	\$64.98	\$60.73	\$101.33	\$64.49	\$61.18	\$63.82
VISION CARE - MATERIALS & FITTING	Service	\$22.90	\$23.27	\$19.68	\$25.76	\$19.91	\$18.77	\$22.34
CHEMICAL DEPENDENCY								
CD SERVICES - ALTERNATIVE TO DETOX	Claims	\$751.50	\$702.76	\$470.29			\$583.87	\$655.81
CD SERVICES - METHADONE	Service	\$8.06	\$7.78	\$8.73		\$7.86	\$9.25	\$7.85
CD SERVICES - OP	Service	\$9.18	\$9.68	\$9.55	\$20.40	\$12.89	\$10.85	\$9.19

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Calculation of Encounter Billed Charges/Unit

7/99 - 6/01 MMIS Data

Charges per Unit by Medicaid Eligibility Category

CATEGORY OF SERVICE	TYPE OF UNITS	TANF BILLED CHGS/UNIT	GA BILLED CHGS/UNIT	PLMA BILLED CHGS/UNIT	CHILDREN 00-01 BILLED CHGS/UNIT	CHILDREN 01-05 BILLED CHGS/UNIT	CHILDREN 06-18 BILLED CHGS/UNIT	OHPFAM BILLED CHGS/UNIT
DENTAL								
DENTAL - ADJUNCTIVE GENERAL	Service	\$54.85	\$52.10	\$60.40	\$55.63	\$116.70	\$62.97	\$55.12
DENTAL - ANESTHESIA SURGICAL	Claims	\$56.64	\$64.21	\$62.98	\$10.71	\$43.67	\$37.54	\$70.46
DENTAL - DIAGNOSTIC	Service	\$30.15	\$29.09	\$29.98	\$33.21	\$23.92	\$25.74	\$29.92
DENTAL - ENDODONTICS	Service	\$289.37	\$293.87	\$267.29	\$335.98	\$82.41	\$166.50	\$287.20
DENTAL - I/P FIXED	Service	\$288.33	\$468.93	\$376.30			\$145.39	\$278.33
DENTAL - MAXILLOFACIAL PROS	Service	\$14.71	\$31.25	\$0.00		\$1,200.00	\$0.00	\$0.00
DENTAL - ORAL SURGERY	Service	\$92.58	\$86.57	\$100.36	\$89.23	\$70.58	\$82.64	\$93.71
DENTAL - ORTHODONTICS	Service	\$118.33		\$0.00		\$33.75	\$571.17	\$233.33
DENTAL - PERIODONTICS	Service	\$95.43	\$83.96	\$76.48	\$140.00	\$117.50	\$76.42	\$86.37
DENTAL - PREVENTIVE	Service	\$44.37	\$46.57	\$44.48	\$29.59	\$48.12	\$40.82	\$46.38
DENTAL - PROS REMOVABLE	Service	\$406.91	\$397.14	\$415.02		\$449.99	\$285.93	\$407.27
DENTAL - RESTORATIVE	Service	\$85.74	\$86.90	\$72.43	\$61.16	\$83.40	\$69.81	\$82.46
DENTAL - TOBACCO CES	Service	\$8.99	\$9.10	\$7.71		\$5.00	\$8.78	\$8.68
MENTAL HEALTH								
MH SERVICES ACUTE INPATIENT	Days	\$910.66	\$918.45	\$867.65		\$1,305.18	\$999.49	\$942.28
MH SERVICES ASSESS & EVAL	Service	\$26.76	\$28.10	\$29.66	\$20.75	\$26.05	\$27.66	\$27.74
MH SERVICES CASE MANAGEMENT	Service	\$21.14	\$20.55	\$22.56	\$21.73	\$20.71	\$21.62	\$22.03
MH SERVICES CONSULTATION	Service	\$23.08	\$21.98	\$23.10	\$19.73	\$22.33	\$22.81	\$22.89
MH SERVICES ANCILLARY SERVICES	Service	\$10.89	\$8.79	\$22.79		\$19.56	\$16.01	\$13.98
MH SERVICES MED MANAGEMENT	Service	\$33.23	\$31.27	\$34.81	\$35.26	\$36.55	\$34.50	\$32.82
MH SERVICES ALTERNATIVE TO IP	Service	\$14.25	\$22.31	\$242.32			\$187.71	\$12.98
MH SERVICES FAMILY SUPPORT	Service	\$10.47	\$7.91	\$7.41	\$5.25	\$8.98	\$8.05	\$10.35
MH SERVICES OP THERAPY	Service	\$19.09	\$17.15	\$19.98	\$19.05	\$19.08	\$20.91	\$20.09
MH SERVICES OTHER OP	Service	\$146.04	\$160.19	\$155.01		\$2,239.85	\$655.89	\$172.56
MH SERVICES PHYS IP	Service	\$115.80	\$94.68	\$70.10		\$144.08	\$113.23	\$107.96
MH SERVICES PHYS OP	Service	\$25.84	\$30.70	\$29.16	\$52.44	\$11.51	\$25.49	\$27.95
MH SERVICES SUPPORT DAY PROGRAM	Service	\$9.54	\$8.19	\$11.21	\$22.01	\$7.79	\$16.24	\$9.31

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Calculation of Encounter Billed Charges/Unit

7/99 - 6/01 MMIS Data

Charges per Unit by Medicaid Eligibility Category

CATEGORY OF SERVICE	TYPE OF UNITS	OHPAC BILLED CHGS/UNIT	ABAD-MED BILLED CHGS/UNIT	ABAD BILLED CHGS/UNIT	OAA-MED BILLED CHGS/UNIT	OAA BILLED CHGS/UNIT	SCF BILLED CHGS/UNIT	CAWEM BILLED CHGS/UNIT
PHYSICAL HEALTH								
ADMINISTRATIVE EXAMS	Claims							
ANESTHESIA	Claims	\$649.70	\$550.68	\$658.53	\$503.73	\$604.43	\$564.16	\$1,154.90
EXCEPT NEEDS CARE COORDINATION	Cases							
FP - IP HOSP	Admits							
FP - OP HOSP	Claims	\$53.98	\$37.55	\$47.20			\$41.51	
FP - PHYS	Service	\$52.60	\$55.91	\$63.03	\$64.02		\$55.59	
HYSTERECTOMY - ANESTHESIA	Claims	\$907.28	\$609.79	\$830.67	\$736.02			
HYSTERECTOMY - IP HOSP	Admits	\$9,049.66	\$7,985.99	\$9,319.16	\$16,560.41	\$18,588.80		
HYSTERECTOMY - OP HOSP	Claims	\$683.46	\$81.40	\$66.95	\$180.63			
HYSTERECTOMY - PHYS	Service	\$1,350.00	\$1,200.08	\$1,305.76	\$1,308.97	\$906.19		
IP HOSP - ACUTE DETOX	Admits	\$2,931.58	\$4,397.26	\$3,755.94	\$5,451.84	\$1,176.38		
IP HOSP - MATERNITY	Admits	\$4,979.24	\$5,651.06	\$5,009.92	\$4,141.89		\$3,999.67	\$4,195.31
IP HOSP - MEDICAL/SURGICAL	Admits	\$12,012.92	\$11,620.23	\$11,923.04	\$10,462.47	\$13,074.00	\$9,016.36	
IP HOSP - NEWBORN	Admits			\$127,757.56			\$19,492.55	
LAB & RAD - DIAGNOSTIC X-RAY	Service	\$103.61	\$78.69	\$94.85	\$69.70	\$79.54	\$84.07	\$89.34
LAB & RAD - LAB	Service	\$27.36	\$26.74	\$26.93	\$25.25	\$24.56	\$21.79	\$30.56
LAB & RAD - THERAPEUTIC X-RAY	Service	\$273.03	\$233.56	\$271.30	\$255.99	\$245.67	\$187.84	
OP ER - SOMATIC MH	Claims	\$192.65	\$219.58	\$200.04	\$279.64	\$188.82	\$189.60	
OP HOSP - BASIC	Claims	\$208.06	\$256.31	\$208.02	\$248.64	\$332.61	\$200.91	\$157.92
OP HOSP - EMERGENCY ROOM	Claims	\$191.30	\$250.54	\$210.67	\$331.76	\$295.95	\$165.07	\$195.34
OP HOSP - LAB & RAD	Claims	\$94.09	\$92.93	\$86.11	\$84.38	\$82.53	\$73.06	\$99.78
OP HOSP - MATERNITY	Claims	\$55.11	\$74.64	\$74.75	\$39.77		\$61.69	\$93.04
OP HOSP - SOMATIC MH	Claims	\$65.73	\$73.59	\$57.38	\$71.15	\$77.89	\$54.29	
OTH MED - DME	Claims	\$145.76	\$180.69	\$185.14	\$137.55	\$107.72	\$153.88	
OTH MED - HHC/PDN	Service	\$42.02	\$42.92	\$38.94	\$50.44	\$52.44	\$36.72	\$49.49
OTH MED - HOSPICE	Claims	\$102.05	\$58.84	\$101.66	\$104.44	\$102.20	\$26.01	
OTH MED - MATERNITY MGT	Cases	\$92.28		\$210.82			\$44.28	
OTH MED - SUPPLIES	Claims	\$56.30	\$68.99	\$82.36	\$72.88	\$103.57	\$85.42	\$11.60
PHYS CONSULTATION, IP & ER VISITS	Service	\$152.65	\$109.82	\$143.99	\$124.79	\$131.32	\$148.58	\$178.98
PHYS HOME OR LONG-TERM CARE VISITS	Service	\$94.01	\$65.33	\$81.51	\$62.61	\$65.04	\$84.11	
PHYS MATERNITY	Cases	\$483.78	\$1,168.56	\$1,268.14	\$85.97	\$66.91	\$875.97	\$2,013.80
PHYS NEWBORN	Cases	\$195.37	\$256.73	\$856.84	\$167.84	\$128.32	\$1,353.28	
PHYS OFFICE VISITS	Service	\$75.25	\$67.42	\$74.35	\$69.22	\$73.79	\$76.32	\$72.08
PHYS OTHER	Service	\$37.57	\$18.23	\$29.67	\$14.03	\$16.35	\$38.35	\$11.27
PHYS SOMATIC MH	Service	\$61.30	\$18.59	\$24.86	\$9.74	\$6.93	\$38.64	\$42.33
POST - HOSP EXTENDED CARE	Days	\$169.12	\$243.92	\$192.39	\$179.69	\$152.15	\$549.93	

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Calculation of Encounter Billed Charges/Unit

7/99 - 6/01 MMIS Data

Charges per Unit by Medicaid Eligibility Category

CATEGORY OF SERVICE	TYPE OF UNITS	OHPAC BILLED CHGS/UNIT	ABAD-MED BILLED CHGS/UNIT	ABAD BILLED CHGS/UNIT	OAA-MED BILLED CHGS/UNIT	OAA BILLED CHGS/UNIT	SCF BILLED CHGS/UNIT	CAWEM BILLED CHGS/UNIT
PRES DRUGS - BASIC	Prescriptions	\$29.70	\$38.28	\$36.76	\$25.83	\$26.83	\$29.49	\$27.84
PRES DRUGS - FP	Prescriptions	\$33.43	\$28.55	\$32.55	\$72.61	\$51.46	\$33.70	\$32.19
PRES DRUGS - MH/CD	Prescriptions							
PRES DRUGS - NEURONTIN	Prescriptions	\$106.59	\$124.42	\$121.55	\$84.59	\$74.82	\$97.49	
PRES DRUGS - OP HOSP BASIC	Claims	\$105.45	\$127.48	\$126.91	\$125.62	\$115.88	\$68.37	\$56.53
PRES DRUGS - OP HOSP FP	Claims							
PRES DRUGS - OP HOSP MH/CD	Claims	\$50.41	\$55.37	\$52.88	\$57.66	\$51.49	\$84.94	
PRES DRUGS - TOBACCO CESSATION	Claims	\$45.11	\$47.73	\$49.37	\$45.07	\$47.36	\$41.14	
SCHOOL-BASED HEALTH SERVICES	Service							
STERILIZATION - ANESTHESIA FEMALE	Claims	\$560.25	\$517.17	\$586.15				\$527.17
STERILIZATION - ANESTHESIA MALE	Claims							
STERILIZATION - IP HOSP FEMALE	Admits	\$13,744.04	\$4,977.12	\$5,622.49				\$1,740.37
STERILIZATION - IP HOSP MALE	Admits							
STERILIZATION - OP HOSP FEMALE	Claims	\$149.03	\$166.09	\$147.22	\$91.10		\$122.52	\$238.88
STERILIZATION - OP HOSP MALE	Claims	\$80.35	\$21.00	\$138.18				
STERILIZATION - PHY FEMALE	Service	\$861.55	\$614.38	\$949.54				\$479.20
STERILIZATION - PHY MALE	Service	\$426.39	\$439.41	\$435.69				
SURGERY	Cases	\$508.71	\$404.54	\$419.32	\$442.02	\$629.05	\$331.60	\$902.55
TARGETED CASE MAN - BABIES FIRST	Cases							
TARGETED CASE MAN - HIV	Cases							
THERAPEUTIC ABORTION - IP HOSP	Admits							
THERAPEUTIC ABORTION - OP HOSP	Claims							
THERAPEUTIC ABORTION - PHYS	Service							
TOBACCO CES-IP HSP	Admits	\$435.34	\$455.47	\$447.03	\$460.10	\$466.01	\$1,381.41	
TOBACCO CES-OP HSP	Claims	\$10.19	\$10.83	\$9.85	\$10.73	\$7.76	\$14.45	
TOBACCO CES-PHYS	Service	\$60.00	\$53.53	\$69.76	\$71.08	\$64.39	\$37.84	
TRANSPORTATION - AMBULANCE	Claims	\$381.60	\$325.28	\$380.92	\$312.02	\$327.15	\$416.33	\$314.93
TRANSPORTATION - OTHER	Claims							
VISION CARE - EXAMS & THERAPY	Service	\$64.49	\$64.12	\$68.11	\$69.24	\$66.85	\$61.04	\$96.10
VISION CARE - MATERIALS & FITTING	Service	\$21.92	\$24.43	\$22.53	\$27.89	\$26.18	\$19.59	
CHEMICAL DEPENDENCY								
CD SERVICES - ALTERNATIVE TO DETOX	Claims	\$691.27	\$748.96	\$648.01			\$795.50	
CD SERVICES - METHADONE	Service	\$8.14	\$8.06	\$7.65	\$6.97	\$6.84	\$12.55	
CD SERVICES - OP	Service	\$9.12	\$9.82	\$9.96	\$11.44	\$20.00	\$11.59	\$24.29

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Calculation of Encounter Billed Charges/Unit

7/99 - 6/01 MMIS Data

Charges per Unit by Medicaid Eligibility Category

CATEGORY OF SERVICE	TYPE OF UNITS	OHPAC BILLED CHGS/UNIT	ABAD-MED BILLED CHGS/UNIT	ABAD BILLED CHGS/UNIT	OAA-MED BILLED CHGS/UNIT	OAA BILLED CHGS/UNIT	SCF BILLED CHGS/UNIT	CAWEM BILLED CHGS/UNIT
DENTAL								
DENTAL - ADJUNCTIVE GENERAL	Service	\$53.17	\$63.42	\$68.61	\$43.24	\$41.69	\$79.43	\$143.04
DENTAL - ANESTHESIA SURGICAL	Claims	\$71.91	\$70.96	\$66.40	\$76.55	\$4.33	\$47.09	
DENTAL - DIAGNOSTIC	Service	\$30.26	\$27.67	\$27.70	\$26.97	\$25.62	\$25.59	\$29.96
DENTAL - ENDODONTICS	Service	\$273.25	\$276.04	\$256.42	\$258.90	\$243.36	\$144.39	\$71.00
DENTAL - I/P FIXED	Service	\$400.15	\$404.83	\$413.02	\$455.69	\$330.13		
DENTAL - MAXILLOFACIAL PROS	Service	\$0.36	\$1.55	\$21.30	\$2.43			
DENTAL - ORAL SURGERY	Service	\$88.69	\$88.92	\$88.72	\$87.65	\$81.22	\$87.17	\$58.09
DENTAL - ORTHODONTICS	Service	\$325.00	\$325.00	\$1,551.88			\$168.18	
DENTAL - PERIODONTICS	Service	\$85.69	\$85.53	\$88.35	\$78.97	\$95.04	\$75.30	\$58.14
DENTAL - PREVENTIVE	Service	\$45.42	\$48.88	\$46.21	\$49.17	\$45.96	\$41.19	\$46.31
DENTAL - PROS REMOVABLE	Service	\$405.77	\$324.86	\$340.07	\$292.62	\$300.54	\$332.33	\$574.99
DENTAL - RESTORATIVE	Service	\$84.14	\$86.56	\$86.26	\$89.37	\$83.38	\$68.82	\$53.60
DENTAL - TOBACCO CES	Service	\$8.66	\$10.65	\$10.84	\$9.63	\$17.99	\$17.49	
MENTAL HEALTH								
MH SERVICES ACUTE INPATIENT	Days	\$966.71	\$953.82	\$955.85	\$999.60	\$763.36	\$1,020.25	
MH SERVICES ASSESS & EVAL	Service	\$28.43	\$25.60	\$27.41	\$24.61	\$26.20	\$25.88	\$21.90
MH SERVICES CASE MANAGEMENT	Service	\$21.09	\$20.89	\$21.00	\$21.63	\$21.03	\$21.14	\$23.00
MH SERVICES CONSULTATION	Service	\$22.67	\$21.82	\$22.58	\$22.46	\$22.32	\$22.07	\$22.29
MH SERVICES ANCILLARY SERVICES	Service	\$12.44	\$9.03	\$11.61	\$10.67	\$7.97	\$16.76	
MH SERVICES MED MANAGEMENT	Service	\$32.96	\$27.32	\$29.31	\$32.29	\$29.89	\$34.16	\$30.96
MH SERVICES ALTERNATIVE TO IP	Service	\$13.81	\$18.62	\$19.93	\$77.92		\$231.91	
MH SERVICES FAMILY SUPPORT	Service	\$10.08	\$10.51	\$8.26	\$10.34		\$7.62	
MH SERVICES OP THERAPY	Service	\$18.88	\$17.72	\$18.69	\$20.70	\$16.08	\$18.37	\$12.94
MH SERVICES OTHER OP	Service	\$115.39	\$113.27	\$156.88	\$74.74		\$510.23	
MH SERVICES PHYS IP	Service	\$110.95	\$63.66	\$89.80	\$47.89		\$130.39	
MH SERVICES PHYS OP	Service	\$32.05	\$24.22	\$25.60	\$18.43	\$16.86	\$22.02	
MH SERVICES SUPPORT DAY PROGRAM	Service	\$9.00	\$8.67	\$9.07	\$7.96	\$6.98	\$20.47	

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Calculation of Fee-For-Service Paid/Unit

7/99 - 6/01 MMIS Data

Paid per Unit by Medicaid Eligibility Category

CATEGORY OF SERVICE	TYPE OF UNITS	TANF PAID/UNIT	GA PAID/UNIT	PLMA PAID/UNIT	CHILDREN 00-01 PAID/UNIT	CHILDREN 01-05 PAID/UNIT	CHILDREN 06-18 PAID/UNIT	OHPFAM PAID/UNIT
PHYSICAL HEALTH								
ADMINISTRATIVE EXAMS	Claims	\$165.70	\$121.01	\$193.15	\$20.84	\$109.85	\$234.56	\$143.28
ANESTHESIA	Claims	\$305.64	\$339.02	\$298.46	\$242.57	\$265.43	\$267.54	\$279.33
EXCEPT NEEDS CARE COORDINATION	Cases							
FP - IP HOSP	Admits							
FP - OP HOSP	Claims	\$38.16	\$14.56	\$29.80			\$23.39	\$30.57
FP - PHYS	Service	\$41.21	\$47.64	\$51.79	\$36.50	\$36.20	\$33.40	\$40.52
HYSTERECTOMY - ANESTHESIA	Claims	\$400.91		\$251.94				\$396.33
HYSTERECTOMY - IP HOSP	Admits	\$3,430.89	\$5,519.43	\$3,032.91			\$2,197.86	\$3,805.72
HYSTERECTOMY - OP HOSP	Claims							
HYSTERECTOMY - PHYS	Service	\$349.38	\$445.02	\$253.86			\$331.64	\$352.85
IP HOSP - ACUTE DETOX	Admits	\$1,457.18	\$1,456.72	\$1,716.92			\$1,801.96	\$1,540.43
IP HOSP - MATERNITY	Admits	\$1,751.35	\$1,250.44	\$1,620.23			\$1,901.08	\$1,500.81
IP HOSP - MEDICAL/SURGICAL	Admits	\$4,851.09	\$5,458.86	\$4,730.12	\$3,581.68	\$3,278.28	\$4,420.66	\$5,199.82
IP HOSP - NEWBORN	Admits	\$463.53		\$414.61	\$1,958.84	\$762.50	\$254.02	\$1,829.88
LAB & RAD - DIAGNOSTIC X-RAY	Service	\$34.34	\$29.52	\$47.32	\$16.46	\$20.21	\$21.57	\$31.27
LAB & RAD - LAB	Service	\$13.40	\$13.48	\$12.85	\$7.89	\$8.79	\$10.60	\$13.06
LAB & RAD - THERAPEUTIC X-RAY	Service	\$57.43	\$59.50	\$42.72	\$21.83	\$38.68	\$53.43	\$57.64
OP ER - SOMATIC MH	Claims							
OP HOSP - BASIC	Claims	\$62.76	\$65.06	\$46.97	\$49.83	\$66.57	\$65.61	\$69.46
OP HOSP - EMERGENCY ROOM	Claims	\$61.85	\$71.58	\$63.65	\$57.18	\$53.22	\$57.19	\$64.77
OP HOSP - LAB & RAD	Claims	\$30.13	\$31.65	\$24.38	\$19.11	\$20.45	\$27.22	\$31.35
OP HOSP - MATERNITY	Claims	\$26.08	\$42.75	\$22.90	\$28.52	\$18.12	\$26.09	\$21.34
OP HOSP - SOMATIC MH	Claims	\$26.67	\$21.51	\$22.13	\$37.67	\$69.79	\$31.32	\$26.01
OTH MED - DME	Claims	\$91.11	\$145.52	\$41.70	\$81.56	\$43.25	\$76.58	\$86.76
OTH MED - HHC/PDN	Service	\$15.57	\$19.26	\$11.27	\$15.03	\$13.07	\$11.65	\$15.73
OTH MED - HOSPICE	Claims	\$85.38	\$110.85		\$110.10		\$233.74	\$102.53
OTH MED - MATERNITY MGT	Cases	\$155.04	\$82.01	\$135.17			\$184.38	\$136.07
OTH MED - SUPPLIES	Claims	\$51.40	\$41.52	\$45.44	\$54.14	\$43.46	\$37.57	\$42.47
PHYS CONSULTATION, IP & ER VISITS	Service	\$54.72	\$50.87	\$54.08	\$56.70	\$50.06	\$51.69	\$57.71
PHYS HOME OR LONG-TERM CARE VISITS	Service	\$65.09	\$40.37	\$65.22	\$67.30	\$68.33	\$69.96	\$53.25
PHYS MATERNITY	Cases	\$635.87	\$510.25	\$556.53	\$121.71	\$27.51	\$598.01	\$544.82
PHYS NEWBORN	Cases	\$105.46	\$81.43	\$59.46	\$215.81	\$116.81	\$103.61	\$85.66
PHYS OFFICE VISITS	Service	\$56.80	\$45.58	\$47.37	\$55.59	\$45.73	\$57.77	\$48.48
PHYS OTHER	Service	\$14.90	\$12.42	\$14.32	\$16.17	\$17.41	\$22.73	\$17.69
PHYS SOMATIC MH	Service	\$33.38	\$40.12	\$21.12	\$19.99	\$12.76	\$13.00	\$44.06
POST - HOSP EXTENDED CARE	Days		\$0.00			\$0.00		\$0.00

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Calculation of Fee-For-Service Paid/Unit

7/99 - 6/01 MMIS Data

Paid per Unit by Medicaid Eligibility Category

CATEGORY OF SERVICE	TYPE OF UNITS	TANF PAID/UNIT	GA PAID/UNIT	PLMA PAID/UNIT	CHILDREN 00-01 PAID/UNIT	CHILDREN 01-05 PAID/UNIT	CHILDREN 06-18 PAID/UNIT	OHPFAM PAID/UNIT
PRES DRUGS - BASIC	Prescriptions	\$26.58	\$44.16	\$18.45	\$18.43	\$18.56	\$27.71	\$30.06
PRES DRUGS - FP	Prescriptions	\$29.91	\$32.14	\$36.45	\$31.78	\$27.60	\$30.24	\$30.55
PRES DRUGS - MH/CD	Prescriptions	\$59.48	\$75.62	\$54.68	\$10.02	\$26.13	\$60.09	\$58.09
PRES DRUGS - NEURONTIN	Prescriptions	\$120.94	\$112.32	\$89.87		\$89.48	\$95.17	\$114.33
PRES DRUGS - OP HOSP BASIC	Claims	\$29.62	\$63.90	\$23.20	\$30.87	\$20.86	\$27.34	\$41.36
PRES DRUGS - OP HOSP FP	Claims							
PRES DRUGS - OP HOSP MH/CD	Claims	\$50.67	\$55.76	\$30.44	\$12.56	\$29.39	\$53.71	\$34.65
PRES DRUGS - TOBACCO CESSATION	Claims	\$63.29	\$64.88	\$57.87		\$70.22	\$57.86	\$64.67
SCHOOL-BASED HEALTH SERVICES	Service	\$14.20	\$10.65	\$16.16	\$19.68	\$15.25	\$16.36	\$22.12
STERILIZATION - ANESTHESIA FEMALE	Claims	\$271.01		\$269.06			\$288.41	\$281.53
STERILIZATION - ANESTHESIA MALE	Claims				\$265.20			\$165.24
STERILIZATION - IP HOSP FEMALE	Admits	\$2,086.25		\$1,699.43			\$1,316.44	\$1,503.61
STERILIZATION - IP HOSP MALE	Admits							
STERILIZATION - OP HOSP FEMALE	Claims	\$54.97	\$30.86	\$45.81			\$42.92	\$73.21
STERILIZATION - OP HOSP MALE	Claims	\$49.14	\$5.94					\$137.31
STERILIZATION - PHY FEMALE	Service	\$143.03		\$116.60			\$220.17	\$185.03
STERILIZATION - PHY MALE	Service	\$263.42	\$230.10					\$247.18
SURGERY	Cases	\$140.62	\$217.25	\$34.65	\$68.39	\$122.29	\$132.07	\$164.52
TARGETED CASE MAN - BABIES FIRST	Cases				\$323.68	\$392.02		
TARGETED CASE MAN - HIV	Cases	\$256.00	\$353.27					\$426.67
THERAPEUTIC ABORTION - IP HOSP	Admits	\$12,862.59		\$2,093.98			\$9,596.46	\$2,077.28
THERAPEUTIC ABORTION - OP HOSP	Claims	\$197.95	\$299.22	\$180.79	\$100.94		\$163.08	\$199.64
THERAPEUTIC ABORTION - PHYS	Service	\$200.49	\$197.98	\$200.07	\$74.92	\$99.90	\$196.71	\$211.86
TOBACCO CES-IP HSP	Admits	\$143.74	\$227.48	\$86.88			\$120.86	\$182.39
TOBACCO CES-OP HSP	Claims	\$2.92	\$3.19	\$2.30	\$2.06	\$2.26	\$2.31	\$3.06
TOBACCO CES-PHYS	Service	\$68.75	\$51.46	\$85.13	\$97.22	\$58.40	\$79.17	\$34.94
TRANSPORTATION - AMBULANCE	Claims	\$98.48	\$60.59	\$158.70	\$320.47	\$159.88	\$125.10	\$122.61
TRANSPORTATION - OTHER	Claims	\$9.61	\$9.49	\$9.28	\$12.27	\$12.47	\$12.10	\$8.66
VISION CARE - EXAMS & THERAPY	Service	\$46.22	\$45.45	\$50.62	\$45.05	\$44.19	\$47.08	\$50.15
VISION CARE - MATERIALS & FITTING	Service	\$9.90	\$10.52	\$9.68	\$12.08	\$11.49	\$9.73	\$9.98
CHEMICAL DEPENDENCY								
CD SERVICES - ALTERNATIVE TO DETOX	Claims							
CD SERVICES - METHADONE	Service	\$6.98	\$7.45	\$7.21			\$12.20	\$6.88
CD SERVICES - OP	Service	\$7.86	\$8.70	\$8.06		\$0.00	\$9.01	\$7.99

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Calculation of Fee-For-Service Paid/Unit

7/99 - 6/01 MMIS Data

Paid per Unit by Medicaid Eligibility Category

CATEGORY OF SERVICE	TYPE OF UNITS	TANF PAID/UNIT	GA PAID/UNIT	PLMA PAID/UNIT	CHILDREN 00-01 PAID/UNIT	CHILDREN 01-05 PAID/UNIT	CHILDREN 06-18 PAID/UNIT	OHPFAM PAID/UNIT
DENTAL								
DENTAL - ADJUNCTIVE GENERAL	Service	\$28.86	\$52.53	\$25.11		\$45.69	\$19.71	\$23.85
DENTAL - ANESTHESIA SURGICAL	Claims	\$25.96	\$60.77	\$22.66		\$15.53	\$10.33	\$38.76
DENTAL - DIAGNOSTIC	Service	\$18.52	\$18.07	\$19.04	\$21.60	\$16.39	\$16.02	\$17.65
DENTAL - ENDODONTICS	Service	\$139.30	\$130.34	\$82.60		\$39.20	\$68.42	\$135.63
DENTAL - I/P FIXED	Service							\$0.00
DENTAL - MAXILLOFACIAL PROS	Service						\$0.00	\$0.00
DENTAL - ORAL SURGERY	Service	\$54.83	\$52.04	\$60.14		\$44.12	\$42.67	\$57.41
DENTAL - ORTHODONTICS	Service	\$0.00						
DENTAL - PERIODONTICS	Service	\$32.31	\$33.22	\$36.08	\$30.90		\$33.36	\$30.15
DENTAL - PREVENTIVE	Service	\$25.22	\$28.87	\$26.98		\$26.22	\$22.14	\$22.61
DENTAL - PROS REMOVABLE	Service	\$161.65	\$157.20			\$0.00	\$45.23	\$78.22
DENTAL - RESTORATIVE	Service	\$37.94	\$39.99	\$33.86	\$0.00	\$38.09	\$33.07	\$36.96
DENTAL - TOBACCO CES	Service	\$1.25					\$8.00	\$1.67
MENTAL HEALTH								
MH SERVICES ACUTE INPATIENT	Days	\$296.80	\$140.89	\$362.10	\$307.20	\$390.14	\$285.26	\$304.25
MH SERVICES ASSESS & EVAL	Service	\$20.19	\$21.48	\$20.49	\$14.34	\$20.05	\$19.99	\$20.86
MH SERVICES CASE MANAGEMENT	Service	\$18.84	\$16.72	\$16.77		\$19.80	\$18.87	\$18.52
MH SERVICES CONSULTATION	Service	\$19.97	\$20.17	\$19.91		\$20.02	\$19.82	\$20.52
MH SERVICES ANCILLARY SERVICES	Service	\$6.64	\$7.43	\$7.51		\$6.92	\$7.23	\$7.39
MH SERVICES MED MANAGEMENT	Service	\$27.13	\$26.37	\$26.14		\$28.93	\$27.29	\$27.23
MH SERVICES ALTERNATIVE TO IP	Service	\$190.73	\$227.39				\$50.19	\$190.08
MH SERVICES FAMILY SUPPORT	Service	\$0.01	\$0.01			\$0.01	\$0.01	
MH SERVICES OP THERAPY	Service	\$15.81	\$11.98	\$14.95		\$16.62	\$16.62	\$16.77
MH SERVICES OTHER OP	Service	\$0.00	\$0.00			\$69.33	\$53.44	\$5.15
MH SERVICES PHYS IP	Service	\$57.67	\$29.75	\$36.44		\$33.01	\$44.82	\$61.01
MH SERVICES PHYS OP	Service	\$45.72	\$35.44			\$49.90	\$48.19	\$79.30
MH SERVICES SUPPORT DAY PROGRAM	Service	\$8.26	\$7.32	\$6.35		\$6.24	\$8.71	\$8.52

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Calculation of Fee-For-Service Paid/Unit

7/99 - 6/01 MMIS Data

Paid per Unit by Medicaid Eligibility Category

CATEGORY OF SERVICE	TYPE OF UNITS	OHPAC PAID/UNIT	ABAD-MED PAID/UNIT	ABAD PAID/UNIT	OAA-MED PAID/UNIT	OAA PAID/UNIT	SCF PAID/UNIT	CAWEM PAID/UNIT
PHYSICAL HEALTH								
ADMINISTRATIVE EXAMS	Claims	\$158.72	\$160.82	\$171.77	\$87.29	\$32.08	\$224.57	\$325.51
ANESTHESIA	Claims	\$315.45	\$51.09	\$298.68	\$39.20	\$157.79	\$255.69	\$297.17
EXCEPT NEEDS CARE COORDINATION	Cases							
FP - IP HOSP	Admits							
FP - OP HOSP	Claims	\$19.01	\$5.96	\$26.60	\$1.07		\$29.22	\$183.91
FP - PHYS	Service	\$39.80	\$41.97	\$43.36			\$34.37	\$78.51
HYSTERECTOMY - ANESTHESIA	Claims	\$443.85	\$15.50	\$495.02	\$33.72			\$459.66
HYSTERECTOMY - IP HOSP	Admits	\$4,312.22	\$91.40	\$4,966.35	\$82.53			\$4,855.49
HYSTERECTOMY - OP HOSP	Claims			\$364.97				
HYSTERECTOMY - PHYS	Service	\$384.15	\$4.62	\$372.60	\$4.68			\$356.47
IP HOSP - ACUTE DETOX	Admits	\$1,763.23	\$154.23	\$1,854.85	\$160.04		\$1,657.48	\$1,658.11
IP HOSP - MATERNITY	Admits	\$2,052.55	\$275.86	\$2,266.82			\$1,304.01	\$1,644.98
IP HOSP - MEDICAL/SURGICAL	Admits	\$5,713.98	\$167.99	\$5,315.75	\$255.99	\$2,368.89	\$3,890.17	\$5,780.49
IP HOSP - NEWBORN	Admits			\$9,437.27			\$3,122.97	\$707.45
LAB & RAD - DIAGNOSTIC X-RAY	Service	\$29.34	\$4.01	\$30.10	\$2.62	\$6.96	\$25.64	\$20.63
LAB & RAD - LAB	Service	\$13.92	\$3.36	\$12.07	\$2.44	\$8.89	\$10.10	\$26.17
LAB & RAD - THERAPEUTIC X-RAY	Service	\$61.49	\$4.00	\$56.41	\$1.75	\$25.63	\$77.60	\$50.24
OP ER - SOMATIC MH	Claims							
OP HOSP - BASIC	Claims	\$77.36	\$24.82	\$97.86	\$21.73	\$75.24	\$148.58	\$91.80
OP HOSP - EMERGFSSY ROOM	Claims	\$72.23	\$17.11	\$69.11	\$18.51	\$45.85	\$60.99	\$93.26
OP HOSP - LAB & RAD	Claims	\$31.14	\$5.01	\$25.73	\$4.80	\$12.14	\$21.75	\$24.94
OP HOSP - MATERNITY	Claims	\$22.31	\$6.13	\$24.12	\$0.00	\$8.48	\$24.94	\$37.85
OP HOSP - SOMATIC MH	Claims	\$24.48	\$2.00	\$22.15	\$3.57	\$6.11	\$32.96	\$24.96
OTH MED - DME	Claims	\$109.29	\$68.70	\$166.21	\$40.02	\$76.11	\$124.52	\$91.83
OTH MED - HHC/PDN	Service	\$16.11	\$2.29	\$15.77	\$1.63	\$5.05	\$15.43	\$15.99
OTH MED - HOSPICE	Claims	\$118.99	\$131.64	\$111.04	\$112.90	\$103.55		
OTH MED - MATERNITY MGT	Cases	\$92.34	\$207.23	\$181.52			\$170.47	\$47.25
OTH MED - SUPPLIES	Claims	\$45.55	\$41.00	\$71.72	\$56.44	\$55.11	\$94.20	\$19.79
PHYS CONSULTATION, IP & ER VISITS	Service	\$55.97	\$4.74	\$54.90	\$3.97	\$15.73	\$59.55	\$55.56
PHYS HOME OR LONG-TERM CARE VISITS	Service	\$40.22	\$6.75	\$38.94	\$8.17	\$9.64	\$42.32	
PHYS MATERNITY	Cases	\$323.68	\$224.32	\$566.18	\$0.00		\$536.85	\$564.41
PHYS NEWBORN	Cases	\$90.04	\$35.06	\$405.86	\$12.82	\$10.16	\$440.55	\$56.71
PHYS OFFICE VISITS	Service	\$54.46	\$11.65	\$43.90	\$9.35	\$36.83	\$46.86	\$58.89
PHYS OTHER	Service	\$13.59	\$6.49	\$14.82	\$8.31	\$11.13	\$14.31	\$24.27
PHYS SOMATIC MH	Service	\$40.57	\$9.62	\$9.24	\$3.35	\$4.18	\$10.66	\$21.76
POST - HOSP EXTENDED CARE	Days	\$0.00	\$0.00	\$0.00	\$0.00			

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Calculation of Fee-For-Service Paid/Unit

7/99 - 6/01 MMIS Data

Paid per Unit by Medicaid Eligibility Category

CATEGORY OF SERVICE	TYPE OF UNITS	OHPAC PAID/UNIT	ABAD-MED PAID/UNIT	ABAD PAID/UNIT	OAA-MED PAID/UNIT	OAA PAID/UNIT	SCF PAID/UNIT	CAWEM PAID/UNIT
PRES DRUGS - BASIC	Prescriptions	\$35.48	\$45.08	\$46.63	\$29.11	\$28.52	\$39.73	\$20.61
PRES DRUGS - FP	Prescriptions	\$30.04	\$29.82	\$30.08	\$39.14	\$22.63	\$30.51	\$37.03
PRES DRUGS - MH/CD	Prescriptions	\$59.75	\$86.27	\$79.61	\$55.36	\$45.69	\$71.40	\$57.54
PRES DRUGS - NEURONTIN	Prescriptions	\$113.89	\$124.32	\$129.37	\$76.67	\$74.31	\$89.78	\$119.96
PRES DRUGS - OP HOSP BASIC	Claims	\$48.17	\$29.02	\$76.37	\$10.37	\$34.41	\$43.06	\$34.81
PRES DRUGS - OP HOSP FP	Claims							
PRES DRUGS - OP HOSP MH/CD	Claims	\$42.09	\$81.71	\$65.71	\$52.34	\$66.78	\$48.70	\$11.04
PRES DRUGS - TOBACCO CESSATION	Claims	\$61.58	\$60.43	\$62.71	\$58.16	\$45.67	\$53.53	
SCHOOL-BASED HEALTH SERVICES	Service	\$18.84	\$6.05	\$10.44			\$11.76	\$22.72
STERILIZATION - ANESTHESIA FEMALE	Claims	\$301.20	\$190.74	\$351.26				\$286.20
STERILIZATION - ANESTHESIA MALE	Claims			\$153.00				
STERILIZATION - IP HOSP FEMALE	Admits	\$2,209.88	\$0.00	\$2,582.98				\$1,764.75
STERILIZATION - IP HOSP MALE	Admits							
STERILIZATION - OP HOSP FEMALE	Claims	\$55.86	\$15.86	\$66.07			\$52.02	\$57.92
STERILIZATION - OP HOSP MALE	Claims	\$56.66	\$137.13	\$147.81				\$79.98
STERILIZATION - PHY FEMALE	Service	\$216.29	\$129.83	\$189.58				\$91.72
STERILIZATION - PHY MALE	Service	\$213.27	\$299.33	\$196.05				
SURGERY	Cases	\$215.79	\$34.05	\$129.31	\$27.55	\$128.86	\$102.70	\$373.70
TARGETED CASE MAN - BABIES FIRST	Cases		\$180.00	\$476.34			\$372.49	
TARGETED CASE MAN - HIV	Cases	\$409.60	\$586.81	\$607.21				
THERAPEUTIC ABORTION - IP HOSP	Admits	\$3,588.80	\$173.00					\$1,114.09
THERAPEUTIC ABORTION - OP HOSP	Claims	\$156.21	\$113.07	\$131.70	\$48.95		\$232.80	\$31.34
THERAPEUTIC ABORTION - PHYS	Service	\$208.51	\$129.13	\$182.71	\$81.57		\$169.19	\$159.14
TOBACCO CES-IP HSP	Admits	\$188.78	\$8.25	\$198.91	\$5.91	\$64.22	\$84.21	\$225.32
TOBACCO CES-OP HSP	Claims	\$3.25	\$0.77	\$3.00	\$0.72	\$0.98	\$2.41	\$4.12
TOBACCO CES-PHYS	Service	\$39.36	\$30.40	\$61.67	\$22.46		\$78.00	
TRANSPORTATION - AMBULANCE	Claims	\$112.65	\$18.87	\$44.71	\$18.57	\$20.71	\$121.50	\$161.83
TRANSPORTATION - OTHER	Claims	\$8.69	\$13.06	\$11.74	\$12.75	\$11.34	\$13.12	\$159.82
VISION CARE - EXAMS & THERAPY	Service	\$48.81	\$22.41	\$42.93	\$15.34	\$24.61	\$45.57	\$53.87
VISION CARE - MATERIALS & FITTING	Service	\$10.09	\$10.22	\$10.61	\$9.61	\$9.69	\$9.62	\$423.86
CHEMICAL DEPENDENCY								
CD SERVICES - ALTERNATIVE TO DETOX	Claims							
CD SERVICES - METHADONE	Service	\$7.38	\$7.09	\$7.54	\$6.60		\$7.95	\$5.97
CD SERVICES - OP	Service	\$8.07	\$8.36	\$8.36	\$9.86		\$7.76	\$20.04

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Calculation of Fee-For-Service Paid/Unit

7/99 - 6/01 MMIS Data

Paid per Unit by Medicaid Eligibility Category

CATEGORY OF SERVICE	TYPE OF UNITS	OHPAC PAID/UNIT	ABAD-MED PAID/UNIT	ABAD PAID/UNIT	OAA-MED PAID/UNIT	OAA PAID/UNIT	SCF PAID/UNIT	CAWEM PAID/UNIT
DENTAL								
DENTAL - ADJUNCTIVE GENERAL	Service	\$27.82	\$29.13	\$22.17	\$20.37	\$19.83	\$29.11	
DENTAL - ANESTHESIA SURGICAL	Claims	\$38.89	\$32.94	\$18.54	\$58.04		\$10.86	
DENTAL - DIAGNOSTIC	Service	\$18.48	\$16.82	\$16.76	\$17.35	\$20.15	\$15.93	\$18.19
DENTAL - ENDODONTICS	Service	\$142.52	\$130.22	\$83.11	\$131.44		\$67.63	
DENTAL - I/P FIXED	Service	\$43.26						
DENTAL - MAXILLOFACIAL PROS	Service							
DENTAL - ORAL SURGERY	Service	\$54.95	\$55.24	\$50.72	\$52.61	\$75.19	\$46.23	
DENTAL - ORTHODONTICS	Service	\$0.00					\$2,180.00	
DENTAL - PERIODONTICS	Service	\$34.99	\$33.07	\$32.62	\$34.04		\$37.20	
DENTAL - PREVENTIVE	Service	\$14.76	\$29.20	\$24.00	\$9.49	\$25.00	\$22.13	\$36.71
DENTAL - PROS REMOVABLE	Service	\$101.30	\$126.29	\$142.19	\$154.55	\$26.44	\$30.90	
DENTAL - RESTORATIVE	Service	\$37.81	\$36.93	\$36.62	\$36.94		\$34.51	
DENTAL - TOBACCO CES	Service	\$3.33	\$0.00	\$2.50	\$0.00		\$0.00	
MENTAL HEALTH								
MH SERVICES ACUTE INPATIENT	Days	\$238.77	\$29.28	\$215.79	\$12.81	\$1,177.90	\$309.21	\$237.35
MH SERVICES ASSESS & EVAL	Service	\$21.15	\$18.35	\$20.65	\$18.48	\$18.82	\$20.59	\$21.86
MH SERVICES CASE MANAGEMENT	Service	\$17.79	\$16.50	\$16.47	\$17.96	\$20.67	\$19.04	\$16.60
MH SERVICES CONSULTATION	Service	\$19.68	\$19.69	\$18.82	\$20.65	\$20.41	\$19.36	\$3.64
MH SERVICES ANCILLARY SERVICES	Service	\$7.47	\$7.26	\$7.45	\$3.76		\$7.20	
MH SERVICES MED MANAGEMENT	Service	\$27.05	\$21.52	\$25.60	\$25.38	\$22.60	\$26.77	\$21.52
MH SERVICES ALTERNATIVE TO IP	Service	\$195.68	\$174.25	\$234.93	\$255.91		\$234.58	
MH SERVICES FAMILY SUPPORT	Service	\$0.01	\$0.01	\$0.01	\$0.01		\$0.01	
MH SERVICES OP THERAPY	Service	\$15.08	\$11.96	\$13.94	\$16.43	\$18.58	\$15.33	\$16.55
MH SERVICES OTHER OP	Service	\$11.21	\$3.05	\$60.39	\$8.15	\$0.00	\$31.91	
MH SERVICES PHYS IP	Service	\$42.83	\$4.91	\$44.97	\$4.98	\$9.72	\$35.81	\$29.32
MH SERVICES PHYS OP	Service	\$72.50	\$1.71	\$33.31	\$4.76	\$24.58	\$42.97	
MH SERVICES SUPPORT DAY PROGRAM	Service	\$8.44	\$7.62	\$7.61	\$7.54	\$14.63	\$8.61	

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION
Annual Trend Factors Used to Update Encounter Data to FFY 2003/05

Exhibit 6-A

MEDICAID ELIGIBILITY CATEGORIES *

COST BASED REIMBURSEMENT 2000 to 2002

CATEGORY OF SERVICE	Utilization Change	Cost change	Total
Inpatient Hospital	5.46%	2.89%	8.51%
Outpatient Hospital	5.15%	3.29%	8.60%
Physician & Other	4.88%	0.00%	4.88%
Prescription Drug	10.75%	5.74%	17.10%
Dental	0.79%	2.12%	2.93%
Mental Health/CD	0.43%	2.04%	2.48%

COST BASED REIMBURSEMENT 2002 to 2005

CATEGORY OF SERVICE	Utilization Change	Cost change	Total
Inpatient Hospital	4.10%	3.13%	7.36%
Outpatient Hospital	4.10%	3.13%	7.36%
Physician & Other	6.73%	1.53%	8.37%
Prescription Drug	8.70%	5.17%	14.32%
Dental	0.79%	2.12%	2.93%
Mental Health/CD	0.43%	2.04%	2.48%

* These factors apply to the TANF, PLM, CHIP, AB/AD without Medicare, OAA without Medicare, SCF Children, GA, OHP Families and OHP Adults & Couples eligibility categories.

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION
Annual Trend Factors Used to Update Encounter Data to FFY 2003/05

Exhibit 6-A

DUAL MEDICAID/MEDICARE ELIGIBILITY CATEGORIES **

COST BASED REIMBURSEMENT 2000 to 2002

CATEGORY OF SERVICE	Utilization Change	Cost change	Total
Inpatient Hospital	7.35%	-0.10%	7.23%
Outpatient Hospital	3.91%	3.29%	7.32%
Physician & Other	4.79%	0.00%	4.79%
Prescription Drug	10.75%	5.74%	17.10%
Dental	0.79%	2.12%	2.93%
Mental Health/CD	-3.00%	1.12%	-1.91%

COST BASED REIMBURSEMENT 2002 to 2005

CATEGORY OF SERVICE	Utilization Change	Cost change	Total
Inpatient Hospital	2.26%	3.13%	5.47%
Outpatient Hospital	2.26%	3.13%	5.47%
Physician & Other	4.73%	1.53%	6.34%
Prescription Drug	8.70%	5.17%	14.32%
Dental	0.79%	2.12%	2.93%
Mental Health/CD	-1.12%	1.12%	-0.01%

** These factors apply to the AB/AD with Medicare and OAA with Medicare eligibility categories.

Trend rates for managed care plans are calculated based on a combination of information reported by the Centers for Medicare and Medicaid Services, Office of the Actuary in their projections of national health expenditures; regression models based on health plan encounter data that measure rates of change in utilization of services and billed charges per member per month, subset by major eligibility category and service type; and published reports on expected rates of change in per capita costs for prescription drugs. Where CMS data are used, we have generally applied the measure of expected change in the "commercial" portion of the CMS report. For managed care dental services, the "total" (all payer) CMS expenditure information is used, as dental services have a higher level of patient copay requirement in commercial plans than would be experienced in the OHP. The utilization trends are adjusted to reflect observed trends for inpatient, outpatient, and physician services. Where appropriate, we have used the health plan experience during the data period, and the CMS trend projections for the future.

Prescription drug trends are calculated based on a report issued by Express Scripts, Express Scripts 2001 Drug Trend Report, June 2002. www.express-scripts.com

Separate trend rates are calculated for each year and then combined to develop annualized trend adjustments.

The data are trended from the midpoint of the data reporting period (July 1, 2000) to the midpoint of the projection period (October 1, 2004).

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION
Annual Trend Factors Used to Update Fee-For-Service Data to FFY 2003/05

Exhibit 6-B

MEDICAID ELIGIBILITY CATEGORIES *

MEDICAID PAYMENT BASED REIMBURSEMENT 2000 to 2002

CATEGORY OF SERVICE	Utilization Change	Cost change	Total
Inpatient Hospital	-3.16%	4.35%	1.05%
Outpatient Hospital	7.45%	0.21%	7.68%
Physician & Other	3.48%	5.80%	9.48%
Prescription Drug	-2.54%	8.59%	5.84%
Prescription Drug- MH/CD	9.64%	8.00%	18.41%
Dental	0.79%	2.81%	3.62%
Mental Health/CD	0.43%	2.48%	2.92%

MEDICAID PAYMENT BASED REIMBURSEMENT 2002 to 2005

CATEGORY OF SERVICE	Utilization Change	Cost change	Total
Inpatient Hospital	4.10%	0.42%	4.53%
Outpatient Hospital	4.97%	0.42%	5.41%
Physician & Other	4.98%	1.30%	6.35%
Prescription Drug	-9.90%	9.54%	-1.31%
Prescription Drug- MH/CD	7.05%	5.19%	12.61%
Dental	0.79%	0.52%	1.31%
Mental Health/CD	3.82%	0.97%	4.82%

* These factors apply to the TANF, PLM, CHIP, AB/AD without Medicare, OAA without Medicare, SCF Children, GA, OHP Families and OHP Adults & Couples eligibility categories.

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION
Annual Trend Factors Used to Update Fee-For-Service Data to FFY 2003/05

Exhibit 6-B

DUAL MEDICAID/MEDICARE ELIGIBILITY CATEGORIES **

MEDICAID PAYMENT BASED REIMBURSEMENT 2000 to 2002

CATEGORY OF SERVICE	Utilization Change	Cost change	Total
Inpatient Hospital	2.44%	4.35%	6.90%
Outpatient Hospital	3.72%	0.21%	3.93%
Physician & Other	3.48%	5.80%	9.48%
Prescription Drug	-0.24%	9.03%	8.77%
Prescription Drug- MH/CD	8.78%	10.35%	20.05%
Dental	0.79%	2.81%	3.62%
Mental Health/CD	0.43%	2.48%	2.92%

MEDICAID PAYMENT BASED REIMBURSEMENT 2002 to 2005

CATEGORY OF SERVICE	Utilization Change	Cost change	Total
Inpatient Hospital	4.12%	0.42%	4.55%
Outpatient Hospital	4.97%	0.42%	5.41%
Physician & Other	4.95%	1.30%	6.32%
Prescription Drug	-2.03%	8.78%	6.58%
Prescription Drug- MH/CD	7.90%	9.20%	17.82%
Dental	0.79%	0.52%	1.31%
Mental Health/CD	3.82%	0.97%	4.82%

** These factors apply to the AB/AD with Medicare and OAA with Medicare eligibility categories.

Trend rates for the fee-for-service delivery system are developed based on expected cost increases provided by OMAP and a calculation of total trend based on OHP experience during our data period. Utilization trend is derived by subtracting the cost trend value from the total trend.

Prescription drug trends are calculated using regression models based on fee-for-service claims that measure rates of change in utilization of services, cost of services, and costs per member per month.

Separate trend rates are calculated for each year and then combined to develop annualized trend adjustments.

The data are trended from the midpoint of the data reporting period (July 1, 2000) to the midpoint of the projection period (October 1, 2004).

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION
Calculation of FCHP Monthly Per Capita Cost for October 2003 through September 2005
through Line 557* of the Prioritized List
Excluding services provided on a Fee-For-Service basis to managed care enrollees

CATEGORY OF SERVICE	TANF COST PMPM (trended)	GA COST PMPM (trended)	PLMA COST PMPM (trended)	CHILDREN 00-01 COST PMPM (trended)	CHILDREN 01-05 COST PMPM (trended)	CHILDREN 06-18 COST PMPM (trended)	OHPFAM COST PMPM (trended)
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PHYSICAL HEALTH

ADMINISTRATIVE EXAMS							
ANESTHESIA	\$3.95	\$7.12	\$15.25	\$1.61	\$1.40	\$0.74	\$2.02
EXCEPT NEEDS CARE COORDINATION							
FP - IP HOSP							
FP - OP HOSP	\$0.06	\$0.03	\$0.04	\$0.00	\$0.00	\$0.01	\$0.05
FP - PHYS	\$0.99	\$0.11	\$1.92	\$0.00	\$0.00	\$0.12	\$0.63
HYSTERECTOMY - ANESTHESIA	\$0.09	\$0.03	\$0.02				\$0.08
HYSTERECTOMY - IP HOSP	\$3.63	\$2.18	\$0.50	\$0.02			\$3.07
HYSTERECTOMY - OP HOSP	\$0.01		\$0.00	\$0.00		\$0.00	\$0.04
HYSTERECTOMY - PHYS	\$0.72	\$0.33	\$0.05			\$0.00	\$0.65
IP HOSP - ACUTE DETOX	\$0.86	\$9.01	\$0.16			\$0.05	\$0.83
IP HOSP - MATERNITY	\$42.10	\$2.31	\$391.96			\$1.82	\$3.17
IP HOSP - MEDICAL/SURGICAL	\$45.79	\$316.39	\$11.87	\$62.91	\$11.79	\$9.83	\$35.69
IP HOSP - NEWBORN				\$169.75	\$0.00	\$0.00	
LAB & RAD - DIAGNOSTIC X-RAY	\$10.61	\$20.83	\$26.76	\$3.48	\$1.20	\$2.08	\$7.70
LAB & RAD - LAB	\$7.47	\$11.04	\$16.41	\$1.16	\$1.00	\$1.39	\$5.79
LAB & RAD - THERAPEUTIC X-RAY	\$0.22	\$3.01	\$0.01	\$0.01	\$0.02	\$0.01	\$0.42
OP ER - SOMATIC MH	\$0.36	\$1.57	\$0.10	\$0.00	\$0.01	\$0.07	\$0.20
OP HOSP - BASIC	\$21.69	\$64.37	\$10.74	\$14.75	\$9.94	\$5.55	\$17.67
OP HOSP - EMERGENCY ROOM	\$9.98	\$18.38	\$4.35	\$8.73	\$4.81	\$3.01	\$5.82
OP HOSP - LAB & RAD	\$18.40	\$52.30	\$11.51	\$6.69	\$3.14	\$3.95	\$14.62
OP HOSP - MATERNITY	\$2.27	\$0.37	\$22.85	\$0.00	\$0.00	\$0.11	\$0.54
OP HOSP - SOMATIC MH	\$0.44	\$1.75	\$0.12	\$0.02	\$0.14	\$0.13	\$0.25
OTH MED - DME	\$1.21	\$8.60	\$0.43	\$1.45	\$0.27	\$0.22	\$0.87
OTH MED - HHC/PDN	\$4.09	\$11.70	\$2.11	\$1.80	\$1.14	\$0.93	\$3.35
OTH MED - HOSPICE	\$0.01	\$1.16	\$0.00	\$0.05	\$0.00		\$0.07
OTH MED - MATERNITY MGT	\$0.08	\$0.01	\$0.82	\$0.00	\$0.00	\$0.01	\$0.01
OTH MED - SUPPLIES	\$0.42	\$3.29	\$0.52	\$0.61	\$0.26	\$0.22	\$0.35
PHYS CONSULTATION, IP & ER VISITS	\$7.40	\$22.11	\$8.91	\$14.25	\$2.77	\$1.95	\$4.96
PHYS HOME OR LONG-TERM CARE VISITS	\$0.01	\$0.67	\$0.05	\$0.04	\$0.01	\$0.01	\$0.01
PHYS MATERNITY	\$32.71	\$0.70	\$295.11	\$0.01	\$0.01	\$1.44	\$3.35
PHYS NEWBORN	\$0.09	\$0.09	\$0.52	\$19.96	\$0.08	\$0.05	\$0.03
PHYS OFFICE VISITS	\$23.49	\$39.93	\$10.05	\$57.78	\$20.73	\$11.24	\$21.31
PHYS OTHER	\$4.77	\$22.86	\$2.52	\$11.60	\$2.71	\$1.45	\$4.52
PHYS SOMATIC MH	\$2.49	\$5.82	\$0.55	\$0.07	\$0.46	\$1.03	\$1.76
POST - HOSP EXTENDED CARE	\$0.04	\$0.32	\$0.15	\$0.02	\$0.00	\$0.01	\$0.01

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION
Calculation of FCHP Monthly Per Capita Cost for October 2003 through September 2005
through Line 557* of the Prioritized List
Excluding services provided on a Fee-For-Service basis to managed care enrollees

CATEGORY OF SERVICE	TANF COST PMPM (trended)	GA COST PMPM (trended)	PLMA COST PMPM (trended)	CHILDREN 00-01 COST PMPM (trended)	CHILDREN 01-05 COST PMPM (trended)	CHILDREN 06-18 COST PMPM (trended)	OHPFAM COST PMPM (trended)
PRES DRUGS - BASIC	\$45.57	\$198.31	\$21.21	\$8.64	\$7.33	\$9.87	\$34.45
PRES DRUGS - FP	\$2.03	\$0.35	\$2.11	\$0.01	\$0.01	\$0.37	\$1.83
PRES DRUGS - MH/CD							
PRES DRUGS - NEURONTIN	\$1.94	\$15.57	\$0.06		\$0.00	\$0.05	\$1.00
PRES DRUGS - OP HOSP BASIC	\$4.11	\$9.99	\$2.15	\$3.26	\$1.11	\$0.86	\$3.53
PRES DRUGS - OP HOSP FP							
PRES DRUGS - OP HOSP MH/CD	\$0.09	\$0.46	\$0.02	\$0.00	\$0.00	\$0.01	\$0.05
PRES DRUGS - TOBACCO CESSATION	\$1.00	\$2.11	\$0.28	\$0.00	\$0.00	\$0.03	\$0.71
SCHOOL-BASED HEALTH SERVICES							
STERILIZATION - ANESTHESIA FEMALE	\$0.43	\$0.00	\$1.67			\$0.00	\$0.15
STERILIZATION - ANESTHESIA MALE	\$0.00					\$0.00	\$0.00
STERILIZATION - IP HOSP FEMALE	\$3.86	\$0.12	\$23.02			\$0.00	\$0.38
STERILIZATION - IP HOSP MALE							
STERILIZATION - OP HOSP FEMALE	\$7.62	\$0.64	\$41.80	\$0.01	\$0.00	\$0.39	\$2.36
STERILIZATION - OP HOSP MALE	\$0.01	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.01
STERILIZATION - PHY FEMALE	\$0.49	\$0.00	\$2.08			\$0.00	\$0.16
STERILIZATION - PHY MALE	\$0.07	\$0.03				\$0.00	\$0.25
SURGERY	\$12.01	\$40.72	\$5.06	\$5.24	\$2.38	\$2.75	\$10.32
TARGETED CASE MAN - BABIES FIRST							
TARGETED CASE MAN - HIV							
THERAPEUTIC ABORTION - IP HOSP							
THERAPEUTIC ABORTION - OP HOSP							
THERAPEUTIC ABORTION - PHYS							
TOBACCO CES-IP HSP	\$0.52	\$1.43	\$0.89	\$0.00	\$0.00	\$0.02	\$0.23
TOBACCO CES-OP HSP	\$0.18	\$0.32	\$0.06	\$0.00	\$0.00	\$0.01	\$0.12
TOBACCO CES-PHYS	\$0.25	\$0.47	\$0.12	\$0.00	\$0.00	\$0.02	\$0.20
TRANSPORTATION - AMBULANCE	\$3.28	\$14.24	\$4.69	\$5.01	\$1.14	\$0.82	\$1.96
TRANSPORTATION - OTHER							
VISION CARE - EXAMS & THERAPY	\$1.92	\$2.83	\$1.62	\$0.29	\$0.48	\$1.75	\$2.39
VISION CARE - MATERIALS & FITTING	\$1.86	\$2.50	\$1.40	\$0.02	\$0.17	\$1.20	\$2.14
Total	\$333.74	\$918.47	\$944.59	\$399.23	\$74.52	\$65.58	\$202.07
CHEMICAL DEPENDENCY							
CD SERVICES - ALTERNATIVE TO DETOX	\$0.19	\$1.19	\$0.03			\$0.00	\$0.19
CD SERVICES - METHADONE	\$3.18	\$18.45	\$0.52		\$0.00	\$0.02	\$2.35
CD SERVICES - OP	\$10.58	\$17.90	\$3.90	\$0.00	\$0.00	\$1.08	\$4.83
Total	\$13.96	\$37.53	\$4.44	\$0.00	\$0.00	\$1.10	\$7.37

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION
Calculation of FCHP Monthly Per Capita Cost for October 2003 through September 2005
through Line 557* of the Prioritized List
Excluding services provided on a Fee-For-Service basis to managed care enrollees

CATEGORY OF SERVICE	TANF COST PMPM (trended)	GA COST PMPM (trended)	PLMA COST PMPM (trended)	CHILDREN 00-01 COST PMPM (trended)	CHILDREN 01-05 COST PMPM (trended)	CHILDREN 06-18 COST PMPM (trended)	OHPFAM COST PMPM (trended)
DENTAL							
DENTAL - ADJUNCTIVE GENERAL	\$0.46	\$0.40	\$0.31	\$0.00	\$0.43	\$0.17	\$0.40
DENTAL - ANESTHESIA SURGICAL	\$0.47	\$0.39	\$0.16	\$0.00	\$0.43	\$0.32	\$0.47
DENTAL - DIAGNOSTIC	\$5.07	\$4.52	\$3.78	\$0.04	\$2.32	\$4.20	\$5.78
DENTAL - ENDODONTICS	\$2.81	\$2.34	\$1.70	\$0.00	\$0.94	\$1.25	\$3.05
DENTAL - I/P FIXED	\$0.06	\$0.33	\$0.03			\$0.00	\$0.08
DENTAL - MAXILLOFACIAL PROS	\$0.00	\$0.00			\$0.00		
DENTAL - ORAL SURGERY	\$4.77	\$5.57	\$1.78	\$0.01	\$0.68	\$1.55	\$4.44
DENTAL - ORTHODONTICS	\$0.00				\$0.00	\$0.03	\$0.00
DENTAL - PERIODONTICS	\$2.09	\$2.05	\$0.73	\$0.00	\$0.00	\$0.09	\$2.44
DENTAL - PREVENTIVE	\$1.31	\$1.37	\$1.38	\$0.02	\$1.79	\$4.11	\$1.91
DENTAL - PROS REMOVABLE	\$3.42	\$9.26	\$0.33		\$0.00	\$0.03	\$3.37
DENTAL - RESTORATIVE	\$7.01	\$6.44	\$3.73	\$0.01	\$5.36	\$6.08	\$8.49
DENTAL - TOBACCO CES	\$0.01	\$0.00	\$0.00		\$0.00	\$0.00	\$0.01
Total	\$27.47	\$32.68	\$13.92	\$0.09	\$11.97	\$17.83	\$30.46
MENTAL HEALTH							
MH SERVICES ACUTE INPATIENT	\$4.05	\$44.89	\$0.84		\$0.11	\$2.39	\$2.57
MH SERVICES ASSESS & EVAL	\$2.89	\$8.01	\$1.25	\$0.01	\$0.57	\$1.78	\$1.55
MH SERVICES CASE MANAGEMENT	\$0.72	\$15.53	\$0.16	\$0.00	\$0.21	\$0.86	\$0.31
MH SERVICES CONSULTATION	\$0.23	\$1.46	\$0.05	\$0.00	\$0.10	\$0.38	\$0.07
MH SERVICES ANCILLARY SERVICES	\$0.03	\$0.04	\$0.00		\$0.00	\$0.01	\$0.01
MH SERVICES MED MANAGEMENT	\$1.88	\$14.16	\$0.20	\$0.00	\$0.06	\$0.53	\$0.75
MH SERVICES ALTERNATIVE TO IP	\$0.24	\$10.24	\$0.07			\$0.16	\$0.17
MH SERVICES FAMILY SUPPORT	\$0.04	\$0.31	\$0.00	\$0.00	\$0.04	\$0.17	\$0.00
MH SERVICES OP THERAPY	\$10.86	\$42.38	\$2.80	\$0.02	\$1.75	\$7.79	\$4.70
MH SERVICES OTHER OP	\$0.05	\$0.32	\$0.01		\$0.02	\$0.11	\$0.04
MH SERVICES PHYS IP	\$0.15	\$1.38	\$0.07		\$0.01	\$0.07	\$0.10
MH SERVICES PHYS OP	\$0.71	\$5.14	\$0.20	\$0.00	\$0.10	\$0.27	\$0.33
MH SERVICES PEO	\$0.57	\$0.57	\$0.57	\$0.57	\$0.57	\$0.57	\$0.57
MH SERVICES SUPPORT DAY PROGRAM	\$0.53	\$26.69	\$0.08	\$0.00	\$0.61	\$1.15	\$0.22
Total	\$22.93	\$171.12	\$6.31	\$0.61	\$4.14	\$16.24	\$11.38
TOTAL ALL	\$398.10	\$1,159.80	\$969.27	\$399.92	\$90.63	\$100.75	\$251.28

* Includes Lines 558, 559, 562, 564, 576, 624, and portions of Lines 615, 642, and 721. Inclusion of these lines equates to coverage through Line 566 of the Prioritized List as configured during the 2001-2003 Biennium.

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION
Calculation of FCHP Monthly Per Capita Cost for October 2003 through September 2005
through Line 557* of the Prioritized List

Excluding services provided on a Fee-For-Service basis to managed care enrollees

CATEGORY OF SERVICE	OHPAC COST PMPM (trended)	ABAD-MED COST PMPM (trended)	ABAD COST PMPM (trended)	OAA-MED COST PMPM (trended)	OAA COST PMPM (trended)	SCF COST PMPM (trended)	CAWEM COST PMPM (trended)
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PHYSICAL HEALTH

ADMINISTRATIVE EXAMS							
ANESTHESIA	\$3.31	\$0.51	\$4.23	\$0.51	\$4.59	\$1.13	
EXCEPT NEEDS CARE COORDINATION							
FP - IP HOSP							
FP - OP HOSP	\$0.01	\$0.00	\$0.02			\$0.02	
FP - PHYS	\$0.13	\$0.10	\$0.21	\$0.00		\$0.11	
HYSTERECTOMY - ANESTHESIA	\$0.06	\$0.00	\$0.04	\$0.00			
HYSTERECTOMY - IP HOSP	\$2.81	\$0.03	\$1.83	\$0.03	\$0.92		
HYSTERECTOMY - OP HOSP	\$0.03	\$0.00	\$0.00	\$0.00			
HYSTERECTOMY - PHYS	\$0.52	\$0.00	\$0.33	\$0.00	\$0.11		
IP HOSP - ACUTE DETOX	\$3.06	\$0.10	\$1.59	\$0.03	\$0.06		
IP HOSP - MATERNITY	\$0.74	\$0.15	\$2.61	\$0.00		\$0.88	
IP HOSP - MEDICAL/SURGICAL	\$95.35	\$7.86	\$183.41	\$11.59	\$218.44	\$10.77	
IP HOSP - NEWBORN			\$1.37			\$2.68	
LAB & RAD - DIAGNOSTIC X-RAY	\$10.97	\$1.00	\$12.64	\$1.17	\$15.54	\$2.15	
LAB & RAD - LAB	\$6.77	\$1.15	\$7.32	\$1.04	\$6.45	\$1.79	
LAB & RAD - THERAPEUTIC X-RAY	\$0.97	\$0.03	\$0.93	\$0.06	\$0.83	\$0.00	
OP ER - SOMATIC MH	\$0.44	\$0.81	\$0.87	\$0.23	\$0.10	\$0.18	
OP HOSP - BASIC	\$28.05	\$12.24	\$41.73	\$9.85	\$65.32	\$8.96	
OP HOSP - EMERGENCY ROOM	\$8.75	\$2.79	\$11.10	\$2.44	\$6.93	\$2.63	
OP HOSP - LAB & RAD	\$22.79	\$4.38	\$28.70	\$5.01	\$30.33	\$4.10	
OP HOSP - MATERNITY	\$0.25	\$0.02	\$0.22	\$0.00		\$0.14	
OP HOSP - SOMATIC MH	\$0.54	\$0.12	\$1.19	\$0.06	\$0.34	\$0.66	
OTH MED - DME	\$1.79	\$4.91	\$14.46	\$4.45	\$8.25	\$0.72	
OTH MED - HHC/PDN	\$5.08	\$1.18	\$8.97	\$1.27	\$9.36	\$1.21	
OTH MED - HOSPICE	\$0.19	\$0.28	\$1.71	\$0.62	\$3.35	\$0.01	
OTH MED - MATERNITY MGT	\$0.00		\$0.01			\$0.00	
OTH MED - SUPPLIES	\$0.86	\$7.78	\$9.22	\$8.27	\$11.68	\$0.85	
PHYS CONSULTATION, IP & ER VISITS	\$8.69	\$1.06	\$14.75	\$1.28	\$21.52	\$2.75	
PHYS HOME OR LONG-TERM CARE VISITS	\$0.06	\$0.16	\$0.43	\$0.70	\$2.38	\$0.10	
PHYS MATERNITY	\$0.54	\$0.22	\$1.59	\$0.00	\$0.01	\$0.46	
PHYS NEWBORN	\$0.05	\$0.00	\$0.40	\$0.00	\$0.05	\$1.23	
PHYS OFFICE VISITS	\$24.89	\$6.31	\$30.59	\$6.24	\$30.30	\$15.56	
PHYS OTHER	\$8.92	\$5.47	\$17.16	\$5.97	\$12.13	\$6.83	
PHYS SOMATIC MH	\$2.46	\$2.76	\$4.52	\$1.28	\$1.48	\$3.34	
POST - HOSP EXTENDED CARE	\$0.07	\$0.37	\$0.58	\$0.32	\$0.28	\$0.00	

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION
Calculation of FCHP Monthly Per Capita Cost for October 2003 through September 2005
through Line 557* of the Prioritized List

Excluding services provided on a Fee-For-Service basis to managed care enrollees

CATEGORY OF SERVICE	OHPAC COST PMPM (trended)	ABAD-MED COST PMPM (trended)	ABAD COST PMPM (trended)	OAA-MED COST PMPM (trended)	OAA COST PMPM (trended)	SCF COST PMPM (trended)	CAWEM COST PMPM (trended)
PRES DRUGS - BASIC	\$73.03	\$233.02	\$173.24	\$178.47	\$105.26	\$26.70	
PRES DRUGS - FP	\$0.74	\$0.91	\$0.70	\$0.04	\$0.07	\$0.48	
PRES DRUGS - MH/CD							
PRES DRUGS - NEURONTIN	\$2.68	\$8.84	\$7.90	\$2.48	\$0.76	\$0.36	
PRES DRUGS - OP HOSP BASIC	\$5.20	\$1.98	\$8.31	\$1.50	\$4.89	\$0.77	
PRES DRUGS - OP HOSP FP							
PRES DRUGS - OP HOSP MH/CD	\$0.22	\$0.21	\$0.24	\$0.08	\$0.09	\$0.05	
PRES DRUGS - TOBACCO CESSATION	\$1.29	\$1.40	\$1.19	\$0.23	\$0.13	\$0.03	
SCHOOL-BASED HEALTH SERVICES							
STERILIZATION - ANESTHESIA FEMALE	\$0.02	\$0.01	\$0.04				
STERILIZATION - ANESTHESIA MALE							
STERILIZATION - IP HOSP FEMALE	\$0.09		\$0.23				
STERILIZATION - IP HOSP MALE							
STERILIZATION - OP HOSP FEMALE	\$0.78	\$0.07	\$0.80	\$0.00		\$0.15	
STERILIZATION - OP HOSP MALE	\$0.00	\$0.00	\$0.00				
STERILIZATION - PHY FEMALE	\$0.03	\$0.01	\$0.05				
STERILIZATION - PHY MALE	\$0.04	\$0.02	\$0.01				
SURGERY	\$18.18	\$3.46	\$19.53	\$4.45	\$25.26	\$3.22	
TARGETED CASE MAN - BABIES FIRST							
TARGETED CASE MAN - HIV							
THERAPEUTIC ABORTION - IP HOSP							
THERAPEUTIC ABORTION - OP HOSP							
THERAPEUTIC ABORTION - PHYS							
TOBACCO CES-IP HSP	\$0.57	\$0.02	\$0.49	\$0.01	\$0.18	\$0.02	
TOBACCO CES-OP HSP	\$0.19	\$0.03	\$0.16	\$0.01	\$0.05	\$0.01	
TOBACCO CES-PHYS	\$0.28	\$0.09	\$0.20	\$0.03	\$0.02	\$0.02	
TRANSPORTATION - AMBULANCE	\$4.61	\$4.17	\$10.76	\$6.11	\$16.06	\$1.12	
TRANSPORTATION - OTHER							
VISION CARE - EXAMS & THERAPY	\$2.96	\$1.03	\$2.40	\$1.42	\$3.45	\$1.70	
VISION CARE - MATERIALS & FITTING	\$2.51	\$1.85	\$1.86	\$2.04	\$2.22	\$1.19	
Total	\$352.59	\$318.91	\$632.87	\$259.26	\$609.19	\$105.08	\$0.00
CHEMICAL DEPENDENCY							
CD SERVICES - ALTERNATIVE TO DETOX	\$1.07	\$0.04	\$0.21			\$0.02	
CD SERVICES - METHADONE	\$9.06	\$1.48	\$4.19	\$0.07	\$0.02	\$0.00	
CD SERVICES - OP	\$13.86	\$3.15	\$3.72	\$0.08	\$0.01	\$4.43	
Total	\$23.99	\$4.67	\$8.11	\$0.15	\$0.03	\$4.45	\$0.00

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CATEGORY OF SERVICE	OHPAC COST PMPM (trended)	ABAD-MED COST PMPM (trended)	ABAD COST PMPM (trended)	OAA-MED COST PMPM (trended)	OAA COST PMPM (trended)	SCF COST PMPM (trended)	CAWEM COST PMPM (trended)
DENTAL							
DENTAL - ADJUNCTIVE GENERAL	\$0.40	\$0.53	\$0.43	\$0.34	\$0.31	\$0.21	
DENTAL - ANESTHESIA SURGICAL	\$0.48	\$0.28	\$0.31	\$0.05	\$0.02	\$0.40	
DENTAL - DIAGNOSTIC	\$5.80	\$3.57	\$3.26	\$1.79	\$3.00	\$4.07	
DENTAL - ENDODONTICS	\$2.65	\$1.32	\$1.30	\$0.44	\$1.19	\$0.94	
DENTAL - I/P FIXED	\$0.24	\$0.26	\$0.16	\$0.59	\$0.24		
DENTAL - MAXILLOFACIAL PROS	\$0.00	\$0.00	\$0.00	\$0.00			
DENTAL - ORAL SURGERY	\$6.43	\$3.23	\$2.98	\$1.91	\$3.63	\$1.22	
DENTAL - ORTHODONTICS	\$0.00	\$0.00	\$0.05			\$0.01	
DENTAL - PERIODONTICS	\$2.56	\$1.86	\$1.38	\$0.57	\$1.28	\$0.08	
DENTAL - PREVENTIVE	\$1.78	\$1.82	\$1.55	\$0.76	\$1.08	\$4.16	
DENTAL - PROS REMOVABLE	\$7.75	\$4.84	\$4.35	\$6.35	\$11.28	\$0.03	
DENTAL - RESTORATIVE	\$8.12	\$5.71	\$5.01	\$2.20	\$3.05	\$6.04	
DENTAL - TOBACCO CES	\$0.01	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
Total	\$36.22	\$23.42	\$20.78	\$15.01	\$25.07	\$17.16	\$0.00
MENTAL HEALTH							
MH SERVICES ACUTE INPATIENT	\$9.73	\$3.13	\$30.17	\$0.54	\$0.58	\$14.55	
MH SERVICES ASSESS & EVAL	\$2.69	\$1.90	\$3.15	\$0.35	\$0.49	\$6.10	
MH SERVICES CASE MANAGEMENT	\$1.20	\$8.54	\$8.87	\$0.92	\$0.52	\$6.68	
MH SERVICES CONSULTATION	\$0.19	\$0.72	\$0.97	\$0.20	\$0.11	\$3.62	
MH SERVICES ANCILLARY SERVICES	\$0.01	\$0.02	\$0.10	\$0.01	\$0.10	\$0.04	
MH SERVICES MED MANAGEMENT	\$2.00	\$6.37	\$7.73	\$0.67	\$1.00	\$4.20	
MH SERVICES ALTERNATIVE TO IP	\$1.06	\$3.88	\$4.10	\$0.11		\$6.23	
MH SERVICES FAMILY SUPPORT	\$0.00	\$0.12	\$0.94	\$0.01		\$2.72	
MH SERVICES OP THERAPY	\$8.37	\$10.98	\$15.72	\$1.16	\$0.68	\$46.88	
MH SERVICES OTHER OP	\$0.13	\$0.14	\$0.21	\$0.03		\$0.55	
MH SERVICES PHYS IP	\$0.28	\$0.24	\$0.92	\$0.04		\$0.59	
MH SERVICES PHYS OP	\$1.01	\$0.53	\$1.84	\$0.07	\$0.40	\$2.30	
MH SERVICES PEO	\$0.57	\$0.57	\$0.57	\$0.57	\$0.57	\$0.57	
MH SERVICES SUPPORT DAY PROGRAM	\$1.49	\$27.64	\$24.61	\$3.43	\$3.07	\$12.74	
Total	\$28.73	\$64.78	\$99.88	\$8.12	\$7.51	\$107.76	\$0.00
TOTAL ALL	\$441.53	\$411.78	\$761.65	\$282.53	\$641.80	\$234.45	\$0.00

* Includes Lines 558, 559, 562, 564, 576, 624, and portions of Lines 615, 642, and 721. Inclusion of these lines equates to coverage through Line 566 of the Prioritized List as configured during the 2001-2003 Biennium.

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION
Calculation of FFS Monthly Per Capita Cost for October 2003 through September 2005
through Line 557* of the Prioritized List
Excluding services provided on a Fee-For-Service basis to managed care enrollees

CATEGORY OF SERVICE	TANF COST PMPM (trended)	GA COST PMPM (trended)	PLMA COST PMPM (trended)	CHILDREN 00-01 COST PMPM (trended)	CHILDREN 01-05 COST PMPM (trended)	CHILDREN 06-18 COST PMPM (trended)	OHPFAM COST PMPM (trended)
PHYSICAL HEALTH							
ADMINISTRATIVE EXAMS	\$1.48	\$17.02	\$0.34	\$0.01	\$0.03	\$0.13	\$0.46
ANESTHESIA	\$3.15	\$10.67	\$10.35	\$1.57	\$1.12	\$0.76	\$2.94
EXCEPT NEEDS CARE COORDINATION							
FP - IP HOSP							
FP - OP HOSP	\$0.17	\$0.01	\$0.17			\$0.02	\$0.07
FP - PHYS	\$8.25	\$1.09	\$10.21	\$0.00	\$0.00	\$2.38	\$5.33
HYSTERECTOMY - ANESTHESIA	\$0.14		\$0.02				\$0.14
HYSTERECTOMY - IP HOSP	\$2.15	\$0.73	\$0.15			\$0.00	\$2.13
HYSTERECTOMY - OP HOSP							
HYSTERECTOMY - PHYS	\$0.39	\$0.11	\$0.05			\$0.00	\$0.37
IP HOSP - ACUTE DETOX	\$0.35	\$1.63	\$0.08			\$0.07	\$0.39
IP HOSP - MATERNITY	\$16.90	\$0.33	\$138.75			\$0.91	\$7.69
IP HOSP - MEDICAL/SURGICAL	\$28.43	\$221.97	\$7.12	\$33.54	\$8.11	\$7.82	\$41.56
IP HOSP - NEWBORN	\$0.00		\$0.01	\$258.27	\$0.02	\$0.00	\$0.01
LAB & RAD - DIAGNOSTIC X-RAY	\$5.53	\$16.37	\$14.53	\$2.56	\$0.63	\$1.02	\$4.42
LAB & RAD - LAB	\$4.21	\$6.87	\$11.42	\$0.49	\$0.37	\$0.64	\$2.86
LAB & RAD - THERAPEUTIC X-RAY	\$0.12	\$2.99	\$0.01	\$0.00	\$0.00	\$0.01	\$0.18
OP ER - SOMATIC MH							
OP HOSP - BASIC	\$15.94	\$55.28	\$6.89	\$12.62	\$7.33	\$5.22	\$15.09
OP HOSP - EMERGENCY ROOM	\$7.29	\$11.51	\$3.56	\$5.72	\$3.24	\$2.34	\$5.35
OP HOSP - LAB & RAD	\$10.93	\$33.52	\$8.12	\$3.33	\$1.57	\$2.54	\$10.22
OP HOSP - MATERNITY	\$1.24	\$0.05	\$15.70	\$0.00	\$0.00	\$0.06	\$0.29
OP HOSP - SOMATIC MH	\$0.44	\$1.91	\$0.05	\$0.01	\$0.08	\$0.15	\$0.34
OTH MED - DME	\$1.22	\$21.67	\$0.36	\$2.55	\$0.39	\$0.30	\$0.84
OTH MED - HHC/PDN	\$3.50	\$15.31	\$1.12	\$1.66	\$0.96	\$0.90	\$3.39
OTH MED - HOSPICE	\$0.04	\$7.00		\$0.01		\$0.04	\$0.10
OTH MED - MATERNITY MGT	\$2.22	\$0.05	\$14.66			\$0.16	\$0.22
OTH MED - SUPPLIES	\$0.96	\$7.52	\$0.71	\$1.23	\$0.30	\$0.32	\$0.91
PHYS CONSULTATION, IP & ER VISITS	\$5.00	\$26.67	\$6.26	\$17.70	\$1.95	\$1.48	\$4.87
PHYS HOME OR LONG-TERM CARE VISITS	\$0.08	\$0.97	\$0.82	\$0.34	\$0.01	\$0.01	\$0.03
PHYS MATERNITY	\$21.69	\$0.92	\$166.38	\$0.01	\$0.00	\$1.12	\$6.78
PHYS NEWBORN	\$0.03	\$0.12	\$0.03	\$24.23	\$0.04	\$0.02	\$0.02
PHYS OFFICE VISITS	\$22.18	\$33.39	\$7.83	\$53.67	\$13.15	\$10.22	\$14.87
PHYS OTHER	\$8.01	\$84.21	\$3.16	\$13.71	\$3.16	\$2.33	\$6.16
PHYS SOMATIC MH	\$2.78	\$9.34	\$0.65	\$0.39	\$10.66	\$16.90	\$1.90
POST - HOSP EXTENDED CARE							

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through Line 557* of the Prioritized List
Excluding services provided on a Fee-For-Service basis to managed care enrollees

CATEGORY OF SERVICE	TANF COST PMPM (trended)	GA COST PMPM (trended)	PLMA COST PMPM (trended)	CHILDREN 00-01 COST PMPM (trended)	CHILDREN 01-05 COST PMPM (trended)	CHILDREN 06-18 COST PMPM (trended)	OHPFAM COST PMPM (trended)
PRES DRUGS - BASIC	\$18.86	\$101.08	\$8.40	\$5.14	\$3.73	\$5.00	\$16.58
PRES DRUGS - FP	\$1.83	\$0.69	\$1.78	\$0.00	\$0.00	\$0.34	\$1.86
PRES DRUGS - MH/CD	\$23.66	\$129.98	\$4.59	\$0.01	\$0.13	\$2.39	\$16.15
PRES DRUGS - NEURONTIN	\$1.17	\$8.02	\$0.02		\$0.00	\$0.03	\$0.59
PRES DRUGS - OP HOSP BASIC	\$2.12	\$8.71	\$0.88	\$1.34	\$0.61	\$0.54	\$2.28
PRES DRUGS - OP HOSP FP							
PRES DRUGS - OP HOSP MH/CD	\$0.31	\$2.57	\$0.03	\$0.00	\$0.00	\$0.04	\$0.15
PRES DRUGS - TOBACCO CESSATION	\$0.59	\$1.22	\$0.12		\$0.00	\$0.02	\$0.42
SCHOOL-BASED HEALTH SERVICES	\$0.01	\$0.07	\$0.02	\$0.48	\$1.62	\$2.04	\$0.00
STERILIZATION - ANESTHESIA FEMALE	\$0.42		\$1.42			\$0.00	\$0.24
STERILIZATION - ANESTHESIA MALE				\$0.00			\$0.00
STERILIZATION - IP HOSP FEMALE	\$2.69		\$12.32			\$0.00	\$0.66
STERILIZATION - IP HOSP MALE							
STERILIZATION - OP HOSP FEMALE	\$4.89	\$0.14	\$31.94			\$0.34	\$2.22
STERILIZATION - OP HOSP MALE	\$0.00	\$0.00					\$0.02
STERILIZATION - PHY FEMALE	\$0.32		\$1.15			\$0.00	\$0.20
STERILIZATION - PHY MALE	\$0.03	\$0.04					\$0.14
SURGERY	\$8.39	\$42.32	\$3.69	\$4.55	\$1.81	\$2.26	\$9.41
TARGETED CASE MAN - BABIES FIRST				\$9.58	\$1.92		
TARGETED CASE MAN - HIV	\$0.00	\$0.07					\$0.00
THERAPEUTIC ABORTION - IP HOSP	\$0.15		\$0.22			\$0.01	\$0.02
THERAPEUTIC ABORTION - OP HOSP	\$0.55	\$0.02	\$2.16	\$0.00		\$0.05	\$0.23
THERAPEUTIC ABORTION - PHYS	\$1.79	\$0.16	\$7.82	\$0.00	\$0.00	\$0.17	\$0.90
TOBACCO CES-IP HSP	\$0.30	\$1.26	\$0.34			\$0.02	\$0.25
TOBACCO CES-OP HSP	\$0.15	\$0.22	\$0.07	\$0.00	\$0.00	\$0.01	\$0.12
TOBACCO CES-PHYS	\$0.18	\$0.24	\$0.05	\$0.00	\$0.00	\$0.02	\$0.11
TRANSPORTATION - AMBULANCE	\$3.61	\$17.91	\$3.88	\$6.97	\$1.00	\$0.97	\$2.75
TRANSPORTATION - OTHER	\$1.93	\$24.61	\$0.37	\$0.13	\$0.08	\$0.17	\$0.84
VISION CARE - EXAMS & THERAPY	\$1.58	\$2.38	\$0.93	\$0.19	\$0.31	\$1.12	\$1.41
VISION CARE - MATERIALS & FITTING	\$1.29	\$1.81	\$0.77	\$0.02	\$0.14	\$0.83	\$1.12
Total	\$251.64	\$932.75	\$512.47	\$462.03	\$64.46	\$74.21	\$198.60
CHEMICAL DEPENDENCY							
CD SERVICES - ALTERNATIVE TO DETOX							
CD SERVICES - METHADONE	\$1.50	\$7.50	\$0.36			\$0.00	\$1.37
CD SERVICES - OP	\$11.51	\$13.30	\$1.85			\$1.04	\$5.35
Total	\$13.01	\$20.80	\$2.21	\$0.00	\$0.00	\$1.05	\$6.72

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION
Calculation of FFS Monthly Per Capita Cost for October 2003 through September 2005
through Line 557* of the Prioritized List
Excluding services provided on a Fee-For-Service basis to managed care enrollees

CATEGORY OF SERVICE	TANF COST PMPM (trended)	GA COST PMPM (trended)	PLMA COST PMPM (trended)	CHILDREN 00-01 COST PMPM (trended)	CHILDREN 01-05 COST PMPM (trended)	CHILDREN 06-18 COST PMPM (trended)	OHPFAM COST PMPM (trended)
DENTAL							
DENTAL - ADJUNCTIVE GENERAL	\$0.05	\$0.04	\$0.02		\$0.04	\$0.01	\$0.03
DENTAL - ANESTHESIA SURGICAL	\$0.02	\$0.02	\$0.00		\$0.01	\$0.01	\$0.03
DENTAL - DIAGNOSTIC	\$0.60	\$0.40	\$0.21	\$0.00	\$0.21	\$0.39	\$0.49
DENTAL - ENDODONTICS	\$0.29	\$0.17	\$0.05		\$0.06	\$0.08	\$0.19
DENTAL - I/P FIXED							
DENTAL - MAXILLOFACIAL PROS							
DENTAL - ORAL SURGERY	\$0.48	\$0.43	\$0.12		\$0.06	\$0.11	\$0.38
DENTAL - ORTHODONTICS							
DENTAL - PERIODONTICS	\$0.09	\$0.21	\$0.02	\$0.00		\$0.01	\$0.08
DENTAL - PREVENTIVE	\$0.07	\$0.09	\$0.04		\$0.11	\$0.24	\$0.07
DENTAL - PROS REMOVABLE	\$0.05	\$0.32				\$0.00	\$0.04
DENTAL - RESTORATIVE	\$0.41	\$0.36	\$0.10		\$0.27	\$0.31	\$0.31
DENTAL - TOBACCO CES	\$0.00					\$0.00	\$0.00
Total	\$2.06	\$2.03	\$0.57	\$0.00	\$0.75	\$1.16	\$1.62
MENTAL HEALTH							
MH SERVICES ACUTE INPATIENT	\$2.41	\$36.23	\$0.38	\$0.16	\$0.04	\$2.20	\$2.71
MH SERVICES ASSESS & EVAL	\$2.14	\$7.99	\$0.40	\$0.01	\$0.30	\$0.91	\$0.89
MH SERVICES CASE MANAGEMENT	\$0.31	\$14.33	\$0.06		\$0.09	\$0.41	\$0.21
MH SERVICES CONSULTATION	\$0.11	\$1.20	\$0.02		\$0.05	\$0.16	\$0.04
MH SERVICES ANCILLARY SERVICES	\$0.01	\$0.01	\$0.00		\$0.00	\$0.00	\$0.00
MH SERVICES MED MANAGEMENT	\$0.64	\$6.66	\$0.06		\$0.02	\$0.22	\$0.42
MH SERVICES ALTERNATIVE TO IP	\$0.06	\$3.49				\$0.01	\$0.02
MH SERVICES FAMILY SUPPORT	\$0.00	\$0.00			\$0.00	\$0.00	
MH SERVICES OP THERAPY	\$3.93	\$24.05	\$0.64		\$0.73	\$2.98	\$1.83
MH SERVICES OTHER OP					\$0.01	\$0.02	\$0.00
MH SERVICES PHYS IP	\$0.08	\$1.36	\$0.00		\$0.00	\$0.04	\$0.06
MH SERVICES PHYS OP	\$0.01	\$0.08			\$0.00	\$0.00	\$0.01
MH SERVICES PEO							
MH SERVICES SUPPORT DAY PROGRAM	\$0.19	\$41.23	\$0.03		\$0.25	\$0.63	\$0.25
Total	\$9.88	\$136.63	\$1.60	\$0.17	\$1.51	\$7.58	\$6.44
TOTAL ALL	\$276.59	\$1,092.20	\$516.85	\$462.20	\$66.72	\$84.00	\$213.38

* Includes Lines 558, 559, 562, 564, 576, 624, and portions of Lines 615, 642, and 721. Inclusion of these lines equates to coverage through Line 566 of the Prioritized List as configured during the 2001-2003 Biennium.

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION
Calculation of FFS Monthly Per Capita Cost for October 2003 through September 2005
through Line 557* of the Prioritized List

Excluding services provided on a Fee-For-Service basis to managed care enrollees

CATEGORY OF SERVICE	OHPAC COST PMPM (trended)	ABAD-MED COST PMPM (trended)	ABAD COST PMPM (trended)	OAA-MED COST PMPM (trended)	OAA COST PMPM (trended)	SCF COST PMPM (trended)	CAWEM COST PMPM (trended)
PHYSICAL HEALTH							
ADMINISTRATIVE EXAMS	\$4.07	\$0.27	\$0.44	\$0.01	\$0.01	\$4.78	\$0.00
ANESTHESIA	\$6.13	\$1.00	\$4.61	\$0.36	\$4.11	\$1.01	\$2.07
EXCEPT NEEDS CARE COORDINATION							
FP - IP HOSP							
FP - OP HOSP	\$0.01	\$0.00	\$0.02	\$0.00		\$0.02	\$0.01
FP - PHYS	\$3.60	\$0.55	\$1.15			\$0.81	\$0.02
HYSTERECTOMY - ANESTHESIA	\$0.14	\$0.00	\$0.09	\$0.00			\$0.01
HYSTERECTOMY - IP HOSP	\$2.06	\$0.03	\$1.19	\$0.01			\$0.22
HYSTERECTOMY - OP HOSP			\$0.00				
HYSTERECTOMY - PHYS	\$0.38	\$0.00	\$0.19	\$0.00			\$0.02
IP HOSP - ACUTE DETOX	\$2.74	\$0.08	\$0.89	\$0.01		\$0.06	\$0.01
IP HOSP - MATERNITY	\$1.23	\$0.06	\$1.18			\$0.27	\$25.64
IP HOSP - MEDICAL/SURGICAL	\$135.57	\$3.98	\$115.21	\$5.17	\$78.73	\$8.80	\$16.62
IP HOSP - NEWBORN			\$1.29			\$3.49	\$0.02
LAB & RAD - DIAGNOSTIC X-RAY	\$9.37	\$1.18	\$7.95	\$0.62	\$4.60	\$1.17	\$0.42
LAB & RAD - LAB	\$4.63	\$0.48	\$4.64	\$0.19	\$3.15	\$0.73	\$0.14
LAB & RAD - THERAPEUTIC X-RAY	\$0.87	\$0.05	\$0.71	\$0.02	\$1.58	\$0.02	\$0.02
OP ER - SOMATIC MH							
OP HOSP - BASIC	\$31.45	\$14.35	\$49.39	\$5.24	\$42.21	\$15.14	\$2.17
OP HOSP - EMERGENCY ROOM	\$10.32	\$1.55	\$7.19	\$0.66	\$3.20	\$1.71	\$1.43
OP HOSP - LAB & RAD	\$18.77	\$3.02	\$17.23	\$1.64	\$10.51	\$2.53	\$0.93
OP HOSP - MATERNITY	\$0.18	\$0.01	\$0.08		\$0.01	\$0.05	\$0.11
OP HOSP - SOMATIC MH	\$0.74	\$0.09	\$1.14	\$0.04	\$0.14	\$0.75	\$0.01
OTH MED - DME	\$2.45	\$12.13	\$30.35	\$5.68	\$11.25	\$2.17	\$0.00
OTH MED - HHC/PDN	\$6.85	\$1.65	\$12.34	\$0.42	\$3.52	\$1.41	\$0.49
OTH MED - HOSPICE	\$1.00	\$0.08	\$6.62	\$0.60	\$7.78		
OTH MED - MATERNITY MGT	\$0.04	\$0.08	\$0.16			\$0.03	\$0.00
OTH MED - SUPPLIES	\$2.20	\$16.84	\$26.78	\$21.10	\$26.77	\$3.67	\$0.00
PHYS CONSULTATION, IP & ER VISITS	\$13.16	\$1.06	\$13.71	\$0.61	\$10.90	\$2.40	\$1.17
PHYS HOME OR LONG-TERM CARE VISITS	\$0.04	\$0.17	\$0.60	\$0.53	\$1.33	\$0.03	
PHYS MATERNITY	\$0.85	\$0.22	\$1.20			\$0.48	\$12.05
PHYS NEWBORN	\$0.04	\$0.02	\$0.31	\$0.00	\$0.02	\$0.90	\$0.00
PHYS OFFICE VISITS	\$23.89	\$5.67	\$22.67	\$2.42	\$13.66	\$10.36	\$0.13
PHYS OTHER	\$19.75	\$14.74	\$28.55	\$8.22	\$12.80	\$6.96	\$0.07
PHYS SOMATIC MH	\$4.14	\$2.19	\$37.35	\$1.11	\$2.28	\$39.43	\$0.02
POST - HOSP EXTENDED CARE							

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION
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through Line 557* of the Prioritized List

Excluding services provided on a Fee-For-Service basis to managed care enrollees

CATEGORY OF SERVICE	OHPAC COST PMPM (trended)	ABAD-MED COST PMPM (trended)	ABAD COST PMPM (trended)	OAA-MED COST PMPM (trended)	OAA COST PMPM (trended)	SCF COST PMPM (trended)	CAWEM COST PMPM (trended)
PRES DRUGS - BASIC	\$32.23	\$185.07	\$94.85	\$150.98	\$181.35	\$14.05	\$0.05
PRES DRUGS - FP	\$0.76	\$1.28	\$0.82	\$0.02	\$0.17	\$0.32	\$0.00
PRES DRUGS - MH/CD	\$28.46	\$168.03	\$95.13	\$64.18	\$30.54	\$21.20	\$0.02
PRES DRUGS - NEURONTIN	\$1.48	\$10.07	\$4.83	\$3.35	\$3.04	\$0.23	\$0.00
PRES DRUGS - OP HOSP BASIC	\$4.53	\$3.05	\$6.85	\$0.45	\$3.95	\$0.63	\$0.32
PRES DRUGS - OP HOSP FP							
PRES DRUGS - OP HOSP MH/CD	\$0.63	\$1.31	\$1.41	\$0.20	\$0.96	\$0.08	\$0.00
PRES DRUGS - TOBACCO CESSATION	\$0.69	\$0.93	\$0.59	\$0.23	\$0.18	\$0.02	
SCHOOL-BASED HEALTH SERVICES	\$0.01	\$0.27	\$20.71			\$9.31	\$0.01
STERILIZATION - ANESTHESIA FEMALE	\$0.04	\$0.02	\$0.03				\$0.07
STERILIZATION - ANESTHESIA MALE			\$0.00				
STERILIZATION - IP HOSP FEMALE	\$0.06		\$0.11				\$1.18
STERILIZATION - IP HOSP MALE							
STERILIZATION - OP HOSP FEMALE	\$0.90	\$0.06	\$0.44			\$0.07	\$1.55
STERILIZATION - OP HOSP MALE	\$0.01	\$0.00	\$0.02				\$0.00
STERILIZATION - PHY FEMALE	\$0.03	\$0.03	\$0.03				\$0.01
STERILIZATION - PHY MALE	\$0.02	\$0.01	\$0.01				
SURGERY	\$23.14	\$3.07	\$16.00	\$1.55	\$16.19	\$2.38	\$1.50
TARGETED CASE MAN - BABIES FIRST		\$0.00	\$0.54			\$0.47	
TARGETED CASE MAN - HIV	\$0.00	\$0.07	\$0.05				
THERAPEUTIC ABORTION - IP HOSP	\$0.01	\$0.00					\$0.03
THERAPEUTIC ABORTION - OP HOSP	\$0.11	\$0.01	\$0.04	\$0.00		\$0.02	\$0.01
THERAPEUTIC ABORTION - PHYS	\$0.40	\$0.03	\$0.08	\$0.00		\$0.05	\$0.02
TOBACCO CES-IP HSP	\$0.87	\$0.01	\$0.31	\$0.00	\$0.06	\$0.01	\$0.02
TOBACCO CES-OP HSP	\$0.27	\$0.03	\$0.12	\$0.01	\$0.01	\$0.00	\$0.00
TOBACCO CES-PHYS	\$0.16	\$0.05	\$0.08	\$0.00		\$0.03	
TRANSPORTATION - AMBULANCE	\$9.46	\$11.15	\$12.42	\$12.64	\$28.72	\$0.94	\$0.91
TRANSPORTATION - OTHER	\$4.43	\$12.84	\$8.14	\$7.59	\$6.14	\$1.76	\$0.00
VISION CARE - EXAMS & THERAPY	\$2.08	\$1.04	\$1.75	\$0.63	\$1.20	\$1.02	\$0.00
VISION CARE - MATERIALS & FITTING	\$1.60	\$1.28	\$1.37	\$0.80	\$1.40	\$0.78	\$0.00
Total	\$419.07	\$481.29	\$661.95	\$297.29	\$512.46	\$162.57	\$69.56
CHEMICAL DEPENDENCY							
CD SERVICES - ALTERNATIVE TO DETOX							
CD SERVICES - METHADONE	\$4.42	\$1.63	\$2.01	\$0.02		\$0.01	\$0.00
CD SERVICES - OP	\$17.59	\$3.18	\$3.05	\$0.05		\$8.99	\$0.00
Total	\$22.01	\$4.81	\$5.06	\$0.07	\$0.00	\$8.99	\$0.00

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION
Calculation of FFS Monthly Per Capita Cost for October 2003 through September 2005
through Line 557* of the Prioritized List

Excluding services provided on a Fee-For-Service basis to managed care enrollees

CATEGORY OF SERVICE	OHPAC COST PMPM (trended)	ABAD-MED COST PMPM (trended)	ABAD COST PMPM (trended)	OAA-MED COST PMPM (trended)	OAA COST PMPM (trended)	SCF COST PMPM (trended)	CAWEM COST PMPM (trended)
DENTAL							
DENTAL - ADJUNCTIVE GENERAL	\$0.03	\$0.02	\$0.06	\$0.02	\$0.03	\$0.02	
DENTAL - ANESTHESIA SURGICAL	\$0.03	\$0.01	\$0.02	\$0.00		\$0.01	
DENTAL - DIAGNOSTIC	\$0.56	\$0.34	\$0.42	\$0.14	\$0.15	\$0.54	\$0.00
DENTAL - ENDODONTICS	\$0.15	\$0.06	\$0.09	\$0.01		\$0.07	
DENTAL - I/P FIXED	\$0.00						
DENTAL - MAXILLOFACIAL PROS							
DENTAL - ORAL SURGERY	\$0.50	\$0.22	\$0.31	\$0.10	\$0.04	\$0.12	
DENTAL - ORTHODONTICS						\$0.03	
DENTAL - PERIODONTICS	\$0.07	\$0.09	\$0.05	\$0.01		\$0.01	
DENTAL - PREVENTIVE	\$0.05	\$0.10	\$0.20	\$0.03	\$0.01	\$0.47	\$0.00
DENTAL - PROS REMOVABLE	\$0.08	\$0.31	\$0.16	\$0.42	\$0.04	\$0.00	
DENTAL - RESTORATIVE	\$0.27	\$0.25	\$0.48	\$0.08		\$0.48	
DENTAL - TOBACCO CES	\$0.00		\$0.00				
Total	\$1.74	\$1.40	\$1.79	\$0.81	\$0.28	\$1.75	\$0.00
MENTAL HEALTH							
MH SERVICES ACUTE INPATIENT	\$16.71	\$1.22	\$13.12	\$0.09	\$1.30	\$13.23	\$0.31
MH SERVICES ASSESS & EVAL	\$2.97	\$1.69	\$2.42	\$0.24	\$0.50	\$4.78	\$0.00
MH SERVICES CASE MANAGEMENT	\$1.06	\$6.18	\$3.92	\$0.35	\$0.07	\$3.14	\$0.00
MH SERVICES CONSULTATION	\$0.12	\$0.73	\$0.71	\$0.14	\$0.28	\$1.96	\$0.00
MH SERVICES ANCILLARY SERVICES	\$0.00	\$0.01	\$0.01	\$0.00		\$0.00	
MH SERVICES MED MANAGEMENT	\$1.26	\$3.20	\$2.80	\$0.21	\$0.12	\$2.12	\$0.00
MH SERVICES ALTERNATIVE TO IP	\$0.41	\$0.81	\$0.60	\$0.04		\$0.46	
MH SERVICES FAMILY SUPPORT	\$0.00	\$0.00	\$0.00	\$0.00		\$0.00	
MH SERVICES OP THERAPY	\$3.87	\$7.53	\$8.82	\$0.53	\$1.47	\$19.50	\$0.01
MH SERVICES OTHER OP	\$0.00	\$0.02	\$0.07	\$0.00		\$0.16	
MH SERVICES PHYS IP	\$0.22	\$0.29	\$0.47	\$0.05	\$0.17	\$0.33	\$0.00
MH SERVICES PHYS OP	\$0.02	\$0.00	\$0.06	\$0.00	\$0.12	\$0.03	
MH SERVICES PEO							
MH SERVICES SUPPORT DAY PROGRAM	\$1.35	\$25.45	\$18.48	\$1.15	\$0.44	\$13.65	
Total	\$22.77	\$47.12	\$51.48	\$2.82	\$4.47	\$59.35	\$0.32
TOTAL ALL	\$428.59	\$534.62	\$720.29	\$300.99	\$517.21	\$232.66	\$69.88

* Includes Lines 558, 559, 562, 564, 576, 624, and portions of Lines 615, 642, and 721. Inclusion of these lines equates to coverage through Line 566 of the Prioritized List as configured during the 2001-2003 Biennium.

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION
Summary Monthly Per Capita Cost Trended to October 2003 - September 2005
By Delivery System Through Line 557* of the Prioritized List

PHYSICAL HEALTH	FCHP PER CAPITA RATE	FCHP FFS PER CAPITA RATE	FFS/PCCM PER CAPITA RATE
Temporary Assistance to Needy Families (Adults Only)	\$333.74	\$29.58	\$251.96
General Assistance	\$918.47	\$171.94	\$932.99
PLM Adults	\$944.59	\$15.52	\$512.63
PLM, TANF, and CHIP Children < 1	\$399.23	\$10.21	\$462.36
PLM, TANF, and CHIP Children 1 - 5	\$74.52	\$3.78	\$64.78
PLM, TANF, and CHIP Children 6 - 18	\$65.58	\$4.95	\$74.53
OHP Families	\$202.07	\$18.60	\$198.85
OHP Adults & Couples	\$352.59	\$37.51	\$419.31
Aid to the Blind/Aid to the Disabled with Medicare	\$318.91	\$181.53	\$482.08
Aid to the Blind/Aid to the Disabled without Medicare	\$632.87	\$125.14	\$662.75
Old Age Assistance with Medicare	\$259.26	\$71.78	\$298.17
Old Age Assistance without Medicare	\$609.19	\$36.68	\$513.35
SCF Children	\$105.08	\$37.59	\$163.16
CAWEM (Citizen-Alien Waived Emergency Medical)	\$0.00	\$0.00	\$69.56

CHEMICAL DEPENDENCY	FCHP PER CAPITA RATE	FCHP FFS PER CAPITA RATE	FFS/PCCM PER CAPITA RATE
Temporary Assistance to Needy Families (Adults Only)	\$13.96	\$0.00	\$13.01
General Assistance	\$37.53	\$0.00	\$20.80
PLM Adults	\$4.44	\$0.00	\$2.21
PLM, TANF, and CHIP Children < 1	\$0.00	\$0.00	\$0.00
PLM, TANF, and CHIP Children 1 - 5	\$0.00	\$0.00	\$0.00
PLM, TANF, and CHIP Children 6 - 18	\$1.10	\$0.00	\$1.05
OHP Families	\$7.37	\$0.00	\$6.72
OHP Adults & Couples	\$23.99	\$0.00	\$22.01
Aid to the Blind/Aid to the Disabled with Medicare	\$4.67	\$0.00	\$4.81
Aid to the Blind/Aid to the Disabled without Medicare	\$8.11	\$0.00	\$5.06
Old Age Assistance with Medicare	\$0.15	\$0.00	\$0.07
Old Age Assistance without Medicare	\$0.03	\$0.00	\$0.00
SCF Children	\$4.45	\$0.00	\$8.99
CAWEM (Citizen-Alien Waived Emergency Medical)	\$0.00	\$0.00	\$0.00

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION
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By Delivery System Through Line 557* of the Prioritized List

DENTAL	FCHP PER CAPITA RATE	FCHP FFS PER CAPITA RATE	FFS/PCCM PER CAPITA RATE
Temporary Assistance to Needy Families (Adults Only)	\$27.47	\$0.00	\$2.06
General Assistance	\$32.68	\$0.00	\$2.03
PLM Adults	\$13.92	\$0.00	\$0.57
PLM, TANF, and CHIP Children < 1	\$0.09	\$0.00	\$0.00
PLM, TANF, and CHIP Children 1 - 5	\$11.97	\$0.00	\$0.75
PLM, TANF, and CHIP Children 6 - 18	\$17.83	\$0.00	\$1.16
OHP Families	\$30.46	\$0.00	\$1.62
OHP Adults & Couples	\$36.22	\$0.00	\$1.74
Aid to the Blind/Aid to the Disabled with Medicare	\$23.42	\$0.00	\$1.40
Aid to the Blind/Aid to the Disabled without Medicare	\$20.78	\$0.00	\$1.79
Old Age Assistance with Medicare	\$15.01	\$0.00	\$0.81
Old Age Assistance without Medicare	\$25.07	\$0.00	\$0.28
SCF Children	\$17.16	\$0.00	\$1.75
CAWEM (Citizen-Alien Waived Emergency Medical)	\$0.00	\$0.00	\$0.00

MENTAL HEALTH	FCHP PER CAPITA RATE	FCHP FFS PER CAPITA RATE	FFS/PCCM PER CAPITA RATE
Temporary Assistance to Needy Families (Adults Only)	\$22.93	\$0.00	\$9.88
General Assistance	\$171.12	\$0.00	\$136.63
PLM Adults	\$6.31	\$0.00	\$1.60
PLM, TANF, and CHIP Children < 1	\$0.61	\$0.00	\$0.17
PLM, TANF, and CHIP Children 1 - 5	\$4.14	\$0.00	\$1.51
PLM, TANF, and CHIP Children 6 - 18	\$16.24	\$0.00	\$7.58
OHP Families	\$11.38	\$0.00	\$6.44
OHP Adults & Couples	\$28.73	\$0.00	\$28.01
Aid to the Blind/Aid to the Disabled with Medicare	\$64.78	\$0.00	\$47.12
Aid to the Blind/Aid to the Disabled without Medicare	\$99.88	\$0.00	\$51.48
Old Age Assistance with Medicare	\$8.12	\$0.00	\$2.82
Old Age Assistance without Medicare	\$7.51	\$0.00	\$4.47
SCF Children	\$107.76	\$0.00	\$59.35
CAWEM (Citizen-Alien Waived Emergency Medical)	\$0.00	\$0.00	\$0.32

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Summary Monthly Per Capita Cost Trended to October 2003 - September 2005

By Delivery System Through Line 557* of the Prioritized List

PHYSICAL HEALTH, DENTAL, & CHEMICAL DEPENDENCY	FCHP PER CAPITA RATE	FCHP FFS PER CAPITA RATE	FFS/PCCM PER CAPITA RATE
Temporary Assistance to Needy Families (Adults Only)	\$375.17	\$29.58	\$267.03
General Assistance	\$988.68	\$171.94	\$955.81
PLM Adults	\$962.96	\$15.52	\$515.40
PLM, TANF, and CHIP Children < 1	\$399.32	\$10.21	\$462.37
PLM, TANF, and CHIP Children 1 - 5	\$86.49	\$3.78	\$65.53
PLM, TANF, and CHIP Children 6 - 18	\$84.51	\$4.95	\$76.74
OHP Families	\$239.89	\$18.60	\$207.19
OHP Adults & Couples	\$412.80	\$37.51	\$443.05
Aid to the Blind/Aid to the Disabled with Medicare	\$347.00	\$181.53	\$488.30
Aid to the Blind/Aid to the Disabled without Medicare	\$661.76	\$125.14	\$669.60
Old Age Assistance with Medicare	\$274.42	\$71.78	\$299.05
Old Age Assistance without Medicare	\$634.29	\$36.68	\$513.63
SCF Children	\$126.69	\$37.59	\$173.91
CAWEM (Citizen-Alien Waived Emergency Medical)	\$0.00	\$0.00	\$69.56

PHYSICAL HEALTH, DENTAL, CHEMICAL DEPENDENCY + ADMIN	FCHP PER CAPITA RATE	FCHP FFS PER CAPITA RATE	FFS/PCCM PER CAPITA RATE
Temporary Assistance to Needy Families (Adults Only)	\$407.79	\$29.58	\$267.03
General Assistance	\$1,074.65	\$171.94	\$955.81
PLM Adults	\$1,046.69	\$15.52	\$515.40
PLM, TANF, and CHIP Children < 1	\$434.04	\$10.21	\$462.37
PLM, TANF, and CHIP Children 1 - 5	\$94.01	\$3.78	\$65.53
PLM, TANF, and CHIP Children 6 - 18	\$91.86	\$4.95	\$76.74
OHP Families	\$260.76	\$18.60	\$207.19
OHP Adults & Couples	\$448.70	\$37.51	\$443.05
Aid to the Blind/Aid to the Disabled with Medicare	\$377.17	\$181.53	\$488.30
Aid to the Blind/Aid to the Disabled without Medicare	\$719.31	\$125.14	\$669.60
Old Age Assistance with Medicare	\$298.28	\$71.78	\$299.05
Old Age Assistance without Medicare	\$689.44	\$36.68	\$513.63
SCF Children	\$137.70	\$37.59	\$173.91
CAWEM (Citizen-Alien Waived Emergency Medical)	\$0.00	\$0.00	\$69.56

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Summary Monthly Per Capita Cost Trended to October 2003 - September 2005

By Delivery System Through Line 557* of the Prioritized List

PHYSICAL HEALTH, DENTAL, CHEMICAL DEPENDENCY, & MENTAL HEALTH	FCHP PER CAPITA RATE	FCHP FFS PER CAPITA RATE	FFS/PCCM PER CAPITA RATE
Temporary Assistance to Needy Families (Adults Only)	\$398.10	\$29.58	\$276.91
General Assistance	\$1,159.80	\$171.94	\$1,092.44
PLM Adults	\$969.27	\$15.52	\$517.00
PLM, TANF, and CHIP Children < 1	\$399.92	\$10.21	\$462.54
PLM, TANF, and CHIP Children 1 - 5	\$90.63	\$3.78	\$67.04
PLM, TANF, and CHIP Children 6 - 18	\$100.75	\$4.95	\$84.32
OHP Families	\$251.28	\$18.60	\$213.64
OHP Adults & Couples	\$441.53	\$37.51	\$471.05
Aid to the Blind/Aid to the Disabled with Medicare	\$411.78	\$181.53	\$535.42
Aid to the Blind/Aid to the Disabled without Medicare	\$761.65	\$125.14	\$721.08
Old Age Assistance with Medicare	\$282.53	\$71.78	\$301.88
Old Age Assistance without Medicare	\$641.80	\$36.68	\$518.10
SCF Children	\$234.45	\$37.59	\$233.26
CAWEM (Citizen-Alien Waived Emergency Medical)	\$0.00	\$0.00	\$69.88

HEALTH CARE EXPENSE PLUS ADMINISTRATION	FCHP PER CAPITA RATE	FCHP FFS PER CAPITA RATE	FFS/PCCM PER CAPITA RATE **
Temporary Assistance to Needy Families (Adults Only)	\$432.72	\$29.58	\$276.91
General Assistance	\$1,260.65	\$171.94	\$1,092.44
PLM Adults	\$1,053.56	\$15.52	\$517.00
PLM, TANF, and CHIP Children < 1	\$434.70	\$10.21	\$462.54
PLM, TANF, and CHIP Children 1 - 5	\$98.51	\$3.78	\$67.04
PLM, TANF, and CHIP Children 6 - 18	\$109.51	\$4.95	\$84.32
OHP Families	\$273.13	\$18.60	\$213.64
OHP Adults & Couples	\$479.93	\$37.51	\$471.05
Aid to the Blind/Aid to the Disabled with Medicare	\$447.59	\$181.53	\$535.42
Aid to the Blind/Aid to the Disabled without Medicare	\$827.88	\$125.14	\$721.08
Old Age Assistance with Medicare	\$307.10	\$71.78	\$301.88
Old Age Assistance without Medicare	\$697.61	\$36.68	\$518.10
SCF Children	\$254.84	\$37.59	\$233.26
CAWEM (Citizen-Alien Waived Emergency Medical)	\$0.00	\$0.00	\$69.88

* Includes Lines 558, 559, 562, 564, 576, 624, and portions of Lines 615, 642, and 721. Inclusion of these lines equates to coverage through Line 566 of the Prioritized List as configured during the 2001-2003 Biennium.

** A PCCM case management fee is applied to the portion of FFS population covered by case management.

Note: FCHP refers to a Fully Capitated Health Plan, FFS refers to Fee-For-Service, and PCCM refers to a Primary Care Case Manager.

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 9-A

Expected Distribution of Enrollees by Eligibility Category and Delivery System

Physical Health Services

For 03/05 Biennium

Eligibility Category	Percentage	DELIVERY SYSTEM *		
		FCHP	FFS/PCCM	Total
Temporary Assistance to Needy Families	6.81%	69.15%	30.85%	100.00%
General Assistance	0.66%	62.64%	37.36%	100.00%
PLM Adults	1.80%	63.01%	36.99%	100.00%
PLM, TANF, and CHIP Children < 1	4.74%	67.77%	32.23%	100.00%
PLM, TANF, and CHIP Children 1 - 5	14.35%	68.14%	31.86%	100.00%
PLM, TANF, and CHIP Children 6 - 18	22.73%	67.20%	32.80%	100.00%
OHP Families	9.44%	66.90%	33.10%	100.00%
OHP Adults & Couples	14.68%	69.47%	30.53%	100.00%
Aid to the Blind/Aid to the Disabled with Medicare	4.10%	59.70%	40.30%	100.00%
Aid to the Blind/Aid to the Disabled without Medicare	7.26%	59.70%	40.30%	100.00%
Old Age Assistance with Medicare	6.21%	41.68%	58.32%	100.00%
Old Age Assistance without Medicare	0.32%	41.68%	58.32%	100.00%
SCF Children	2.94%	54.01%	45.99%	100.00%
CAWEM (Citizen-Alien Waived Emergency Medical)	3.95%	0.00%	100.00%	100.00%
	100.0%			

AVERAGE BY ELIGIBILITY CATEGORY AND DELIVERY SYSTEM

For 03/05 Biennium

Eligibility Category	DELIVERY SYSTEM *		
	FCHP	FFS/PCCM	Total
Temporary Assistance to Needy Families	4.71%	2.10%	6.81%
General Assistance	0.41%	0.25%	0.66%
PLM Adults	1.13%	0.67%	1.80%
PLM, TANF, and CHIP Children < 1	3.21%	1.53%	4.74%
PLM, TANF, and CHIP Children 1 - 5	9.78%	4.57%	14.35%
PLM, TANF, and CHIP Children 6 - 18	15.27%	7.46%	22.73%
OHP Families	6.32%	3.13%	9.44%
OHP Adults & Couples	10.20%	4.48%	14.68%
Aid to the Blind/Aid to the Disabled with Medicare	2.45%	1.65%	4.10%
Aid to the Blind/Aid to the Disabled without Medicare	4.34%	2.93%	7.26%
Old Age Assistance with Medicare	2.59%	3.62%	6.21%
Old Age Assistance without Medicare	0.13%	0.19%	0.32%
SCF Children	1.59%	1.35%	2.94%
CAWEM (Citizen-Alien Waived Emergency Medical)	0.00%	3.95%	3.95%
Total	62.13%	37.87%	100.00%

* Eligibility distribution by delivery system was calculated by PwC based on information provided by OMAP.

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 9-B

Expected Distribution of Enrollees by Eligibility Category and Delivery System

Dental Services

For 03/05 Biennium

Eligibility Category	Percentage	DELIVERY SYSTEM *		
		FCHP	FFS/PCCM	Total
Temporary Assistance to Needy Families	6.81%	85.42%	14.58%	100.00%
General Assistance	0.66%	80.49%	19.51%	100.00%
PLM Adults	1.80%	84.77%	15.23%	100.00%
PLM, TANF, and CHIP Children < 1	4.74%	85.96%	14.04%	100.00%
PLM, TANF, and CHIP Children 1 - 5	14.35%	86.63%	13.37%	100.00%
PLM, TANF, and CHIP Children 6 - 18	22.73%	86.55%	13.45%	100.00%
OHP Families	9.44%	85.62%	14.38%	100.00%
OHP Adults & Couples	14.68%	86.36%	13.64%	100.00%
Aid to the Blind/Aid to the Disabled with Medicare	4.10%	89.46%	10.54%	100.00%
Aid to the Blind/Aid to the Disabled without Medicare	7.26%	89.46%	10.54%	100.00%
Old Age Assistance with Medicare	6.21%	88.80%	11.20%	100.00%
Old Age Assistance without Medicare	0.32%	88.80%	11.20%	100.00%
SCF Children	2.94%	78.76%	21.24%	100.00%
CAWEM (Citizen-Alien Waived Emergency Medical)	3.95%	0.00%	100.00%	100.00%
	100.0%			

AVERAGE BY ELIGIBILITY CATEGORY AND DELIVERY SYSTEM

For 03/05 Biennium

Eligibility Category	DELIVERY SYSTEM *		
	FCHP	FFS/PCCM	Total
Temporary Assistance to Needy Families	5.82%	0.99%	6.81%
General Assistance	0.53%	0.13%	0.66%
PLM Adults	1.53%	0.27%	1.80%
PLM, TANF, and CHIP Children < 1	4.08%	0.67%	4.74%
PLM, TANF, and CHIP Children 1 - 5	12.43%	1.92%	14.35%
PLM, TANF, and CHIP Children 6 - 18	19.67%	3.06%	22.73%
OHP Families	8.09%	1.36%	9.44%
OHP Adults & Couples	12.68%	2.00%	14.68%
Aid to the Blind/Aid to the Disabled with Medicare	3.67%	0.43%	4.10%
Aid to the Blind/Aid to the Disabled without Medicare	6.50%	0.77%	7.26%
Old Age Assistance with Medicare	5.52%	0.70%	6.21%
Old Age Assistance without Medicare	0.28%	0.04%	0.32%
SCF Children	2.32%	0.63%	2.94%
CAWEM (Citizen-Alien Waived Emergency Medical)	0.00%	3.95%	3.95%
Total	83.10%	16.90%	100.00%

* Eligibility distribution by delivery system was calculated by PwC based on information provided by OMAP.

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 9-C

Expected Distribution of Enrollees by Eligibility Category and Delivery System

Mental Health Services

For 03/05 Biennium

Eligibility Category	Percentage	DELIVERY SYSTEM *		
		FCHP	FFS/PCCM	Total
Temporary Assistance to Needy Families	6.81%	85.80%	14.20%	100.00%
General Assistance	0.66%	85.90%	14.10%	100.00%
PLM Adults	1.80%	75.18%	24.82%	100.00%
PLM, TANF, and CHIP Children < 1	4.74%	87.47%	12.53%	100.00%
PLM, TANF, and CHIP Children 1 - 5	14.35%	80.39%	19.61%	100.00%
PLM, TANF, and CHIP Children 6 - 18	22.73%	79.92%	20.08%	100.00%
OHP Families	9.44%	77.00%	23.00%	100.00%
OHP Adults & Couples	14.68%	80.30%	19.70%	100.00%
Aid to the Blind/Aid to the Disabled with Medicare	4.10%	89.40%	10.60%	100.00%
Aid to the Blind/Aid to the Disabled without Medicare	7.26%	89.40%	10.60%	100.00%
Old Age Assistance with Medicare	6.21%	76.80%	23.20%	100.00%
Old Age Assistance without Medicare	0.32%	76.80%	23.20%	100.00%
SCF Children	2.94%	76.40%	23.60%	100.00%
CAWEM (Citizen-Alien Waived Emergency Medical)	3.95%	0.00%	100.00%	100.00%
	100.0%			

AVERAGE BY ELIGIBILITY CATEGORY AND DELIVERY SYSTEM

For 03/05 Biennium

Eligibility Category	DELIVERY SYSTEM *		
	FCHP	FFS/PCCM	Total
Temporary Assistance to Needy Families	5.84%	0.97%	6.81%
General Assistance	0.56%	0.09%	0.66%
PLM Adults	1.35%	0.45%	1.80%
PLM, TANF, and CHIP Children < 1	4.15%	0.59%	4.74%
PLM, TANF, and CHIP Children 1 - 5	11.54%	2.81%	14.35%
PLM, TANF, and CHIP Children 6 - 18	18.16%	4.56%	22.73%
OHP Families	7.27%	2.17%	9.44%
OHP Adults & Couples	11.79%	2.89%	14.68%
Aid to the Blind/Aid to the Disabled with Medicare	3.67%	0.43%	4.10%
Aid to the Blind/Aid to the Disabled without Medicare	6.49%	0.77%	7.26%
Old Age Assistance with Medicare	4.77%	1.44%	6.21%
Old Age Assistance without Medicare	0.25%	0.07%	0.32%
SCF Children	2.25%	0.70%	2.94%
CAWEM (Citizen-Alien Waived Emergency Medical)	0.00%	3.95%	3.95%
Total	78.10%	21.90%	100.00%

* Eligibility distribution by delivery system was calculated by PwC based on information provided by OMAP.

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Exhibit 10-A

Average Per Capita Cost* FFY 2004/2005
Through Line 557** of the Prioritized List

Average Monthly Per Capita Cost by Eligibility Category and Delivery System
Physical Health Services Including Administration

Eligibility Category	DELIVERY SYSTEM ***		
	FCHP*	FFS/PCCM	Average
Temporary Assistance to Needy Families	\$392.33	\$251.96	\$349.03
General Assistance	\$1,170.28	\$932.99	\$1,081.62
PLM Adults	\$1,042.25	\$512.63	\$846.36
PLM, TANF, and CHIP Children < 1	\$444.15	\$462.36	\$450.02
PLM, TANF, and CHIP Children 1 - 5	\$84.78	\$64.78	\$78.41
PLM, TANF, and CHIP Children 6 - 18	\$76.24	\$74.53	\$75.68
OHP Families	\$238.24	\$198.85	\$225.20
OHP Adults & Couples	\$420.76	\$419.31	\$420.31
Aid to the Blind/Aid to the Disabled with Medicare	\$528.17	\$482.08	\$509.60
Aid to the Blind/Aid to the Disabled without Medicare	\$813.04	\$662.75	\$752.48
Old Age Assistance with Medicare	\$353.59	\$298.17	\$321.27
Old Age Assistance without Medicare	\$698.84	\$513.35	\$590.66
SCF Children	\$151.81	\$163.16	\$157.03
CAWEM (Citizen-Alien Waived Emergency Medical)	\$0.00	\$69.56	\$69.56
Total			\$283.65

* Per capita cost is a combination of fee-for-service expenditures and capitation payments.

** Includes Lines 558, 559, 562, 564, 576, 624, and portions of Lines 615, 642, and 721. Inclusion of these lines equates to coverage through Line 566 of the Prioritized List as configured during the 2001-2003 Biennium.

*** Eligibility distribution by delivery system was calculated by PwC based on information provided by OMAP.

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Exhibit 10-B

Average Per Capita Cost* FFY 2004/2005
Through Line 557** of the Prioritized List

Average Monthly Per Capita Cost by Eligibility Category and Delivery System
Dental Services Including Administration

Eligibility Category	DELIVERY SYSTEM ***		
	FCHP*	FFS/PCCM	Average
Temporary Assistance to Needy Families	\$29.86	\$2.06	\$25.81
General Assistance	\$35.52	\$2.03	\$28.99
PLM Adults	\$15.13	\$0.57	\$12.91
PLM, TANF, and CHIP Children < 1	\$0.09	\$0.00	\$0.08
PLM, TANF, and CHIP Children 1 - 5	\$13.01	\$0.75	\$11.37
PLM, TANF, and CHIP Children 6 - 18	\$19.38	\$1.16	\$16.93
OHP Families	\$33.10	\$1.62	\$28.58
OHP Adults & Couples	\$39.37	\$1.74	\$34.23
Aid to the Blind/Aid to the Disabled with Medicare	\$25.46	\$1.40	\$22.92
Aid to the Blind/Aid to the Disabled without Medicare	\$22.59	\$1.79	\$20.40
Old Age Assistance with Medicare	\$16.32	\$0.81	\$14.58
Old Age Assistance without Medicare	\$27.25	\$0.28	\$24.23
SCF Children	\$18.65	\$1.75	\$15.06
CAWEM (Citizen-Alien Waived Emergency Medical)	\$0.00	\$0.00	\$0.00
Total			\$19.24

* Per capita cost is a combination of fee-for-service expenditures and capitation payments.

** Includes Lines 558, 559, 562, 564, 576, 624, and portions of Lines 615, 642, and 721. Inclusion of these lines equates to coverage through Line 566 of the Prioritized List as configured during the 2001-2003 Biennium.

*** Eligibility distribution by delivery system was calculated by PwC based on information provided by OMAP.

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Exhibit 10-C

Average Per Capita Cost* FFY 2004/2005

Through Line 557** of the Prioritized List

Average Monthly Per Capita Cost by Eligibility Category and Delivery System
Chemical Dependency Services Including Administration

Eligibility Category	DELIVERY SYSTEM ***		
	FCHP*	FFS/PCCM	Average
Temporary Assistance to Needy Families	\$15.17	\$13.01	\$14.50
General Assistance	\$40.79	\$20.80	\$33.32
PLM Adults	\$4.83	\$2.21	\$3.86
PLM, TANF, and CHIP Children < 1	\$0.00	\$0.00	\$0.00
PLM, TANF, and CHIP Children 1 - 5	\$0.00	\$0.00	\$0.00
PLM, TANF, and CHIP Children 6 - 18	\$1.20	\$1.05	\$1.15
OHP Families	\$8.01	\$6.72	\$7.58
OHP Adults & Couples	\$26.08	\$22.01	\$24.84
Aid to the Blind/Aid to the Disabled with Medicare	\$5.08	\$4.81	\$4.97
Aid to the Blind/Aid to the Disabled without Medicare	\$8.82	\$5.06	\$7.30
Old Age Assistance with Medicare	\$0.16	\$0.07	\$0.11
Old Age Assistance without Medicare	\$0.03	\$0.00	\$0.01
SCF Children	\$4.83	\$8.99	\$6.75
CAWEM (Citizen-Alien Waived Emergency Medical)	\$0.00	\$0.00	\$0.00
Total			\$6.84

* Per capita cost is a combination of fee-for-service expenditures and capitation payments.

** Includes Lines 558, 559, 562, 564, 576, 624, and portions of Lines 615, 642, and 721. Inclusion of these lines equates to coverage through Line 566 of the Prioritized List as configured during the 2001-2003 Biennium.

*** Eligibility distribution by delivery system was calculated by PwC based on information provided by OMAP.

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Exhibit 10-D

Average Per Capita Cost* FFY 2004/2005
Through Line 557** of the Prioritized List

Average Monthly Per Capita Cost by Eligibility Category and Delivery System
Mental Health Services Including Administration

Eligibility Category	DELIVERY SYSTEM ***		
	FCHP*	FFS/PCCM	Average
Temporary Assistance to Needy Families	\$24.93	\$9.88	\$22.79
General Assistance	\$186.00	\$136.63	\$179.04
PLM Adults	\$6.86	\$1.60	\$5.56
PLM, TANF, and CHIP Children < 1	\$0.66	\$0.17	\$0.60
PLM, TANF, and CHIP Children 1 - 5	\$4.50	\$1.51	\$3.91
PLM, TANF, and CHIP Children 6 - 18	\$17.65	\$7.58	\$15.63
OHP Families	\$12.37	\$6.44	\$11.01
OHP Adults & Couples	\$31.23	\$28.01	\$30.60
Aid to the Blind/Aid to the Disabled with Medicare	\$70.42	\$47.12	\$67.95
Aid to the Blind/Aid to the Disabled without Medicare	\$108.57	\$51.48	\$102.52
Old Age Assistance with Medicare	\$8.82	\$2.82	\$7.43
Old Age Assistance without Medicare	\$8.17	\$4.47	\$7.31
SCF Children	\$117.13	\$59.35	\$103.50
CAWEM (Citizen-Alien Waived Emergency Medical)	\$0.00	\$0.32	\$0.32
Total			\$26.28

* Per capita cost is a combination of fee-for-service expenditures and capitation payments.

** Includes Lines 558, 559, 562, 564, 576, 624, and portions of Lines 615, 642, and 721. Inclusion of these lines equates to coverage through Line 566 of the Prioritized List as configured during the 2001-2003 Biennium.

*** Eligibility distribution by delivery system was calculated by PwC based on information provided by OMAP.

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Exhibit 10-E

Average Per Capita Cost* FFY 2004/2005 Through Line 557** of the Prioritized List

Average Monthly Per Capita Cost by Eligibility Category and Delivery System All Services Excluding Mental Health

Eligibility Category	DELIVERY SYSTEM ***		
	FCHP*	FFS/PCCM	Average
Temporary Assistance to Needy Families	\$437.37	\$267.03	\$389.34
General Assistance	\$1,246.59	\$955.81	\$1,143.93
PLM Adults	\$1,062.21	\$515.40	\$863.13
PLM, TANF, and CHIP Children < 1	\$444.25	\$462.37	\$450.10
PLM, TANF, and CHIP Children 1 - 5	\$97.79	\$65.53	\$89.78
PLM, TANF, and CHIP Children 6 - 18	\$96.81	\$76.74	\$93.75
OHP Families	\$279.36	\$207.19	\$261.37
OHP Adults & Couples	\$486.20	\$443.05	\$479.38
Aid to the Blind/Aid to the Disabled with Medicare	\$558.70	\$488.30	\$537.49
Aid to the Blind/Aid to the Disabled without Medicare	\$844.44	\$669.60	\$780.18
Old Age Assistance with Medicare	\$370.06	\$299.05	\$335.96
Old Age Assistance without Medicare	\$726.13	\$513.63	\$614.91
SCF Children	\$175.30	\$173.91	\$178.84
CAWEM (Citizen-Alien Waived Emergency Medical)	\$0.00	\$69.56	\$69.56
Total			\$309.73

* Per capita cost is a combination of fee-for-service expenditures and capitation payments.

** Includes Lines 558, 559, 562, 564, 576, 624, and portions of Lines 615, 642, and 721. Inclusion of these lines equates to coverage through Line 566 of the Prioritized List as configured during the 2001-2003 Biennium.

*** Eligibility distribution by delivery system was calculated by PwC based on information provided by OMAP.

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Exhibit 10-F

Average Per Capita Cost* FFY 2004/2005

Through Line 557** of the Prioritized List

Average Monthly Per Capita Cost by Eligibility Category and Delivery System

All Services

Eligibility Category	DELIVERY SYSTEM ***		
	FCHP*	FFS/PCCM	Average
Temporary Assistance to Needy Families	\$462.30	\$276.91	\$412.13
General Assistance	\$1,432.59	\$1,092.44	\$1,322.97
PLM Adults	\$1,069.08	\$517.00	\$868.69
PLM, TANF, and CHIP Children < 1	\$444.91	\$462.54	\$450.70
PLM, TANF, and CHIP Children 1 - 5	\$102.29	\$67.04	\$93.69
PLM, TANF, and CHIP Children 6 - 18	\$114.46	\$84.32	\$109.38
OHP Families	\$291.73	\$213.64	\$272.38
OHP Adults & Couples	\$517.43	\$471.05	\$509.98
Aid to the Blind/Aid to the Disabled with Medicare	\$629.12	\$535.42	\$605.44
Aid to the Blind/Aid to the Disabled without Medicare	\$953.01	\$721.08	\$882.70
Old Age Assistance with Medicare	\$378.88	\$301.88	\$343.39
Old Age Assistance without Medicare	\$734.29	\$518.10	\$622.21
SCF Children	\$292.43	\$233.26	\$282.34
CAWEM (Citizen-Alien Waived Emergency Medical)	\$0.00	\$69.88	\$69.88
Total			\$336.01

* Per capita cost is a combination of fee-for-service expenditures and capitation payments.

** Includes Lines 558, 559, 562, 564, 576, 624, and portions of Lines 615, 642, and 721. Inclusion of these lines equates to coverage through Line 566 of the Prioritized List as configured during the 2001-2003 Biennium.

*** Eligibility distribution by delivery system was calculated by PwC based on information provided by OMAP.

OREGON BASIC HEALTH SERVICES PROGRAM
Description of Allocation of Claims to Condition/Treatment Pairs

Exhibit 11

TREATMENT TYPE	ICD 9 CODES	CPT 4 CODES	EXPENDITURE ALLOCATION
Initial diagnosis	780-799, V65.5, V71, V72.5, V72.6, V72.7, V73-V78, V80-V82	Any	Beginning of the List
Diagnostic	Any	Biopsies, Other Diagnostic Tests Diagnostic lab and x-ray services	Beginning of the List
Vaccines	Any	90476-90749	Beginning of the List
Anesthesia, Ambulance, DME, Supplies, Orthotics, Vision, Audiology, Drugs coded with HCPCs	Any	00100-01999, Alphanumeric HCPCs beginning with A, E, J, L, or V	Beginning of the List
Surgical treatment, Dental and Mental Health, Psychotherapy	001-779, V01-V82, except those listed under initial diagnosis	02000-69999, ADA Codes, Mental Health OMAP Codes Mental Health CPT4 Codes	Based on the number of line items with matching diagnosis and treatment pairs. Generally, all claims go to a single line.
Medical treatment	001-779, V01-V82, except those listed under initial diagnosis	90000-99999	Based on whether there is a matching surgical treatment and the number of line items with the same range of ICD9 codes. Generally, if there is a single matching surgical line item, 75% of the medical claims are allocated to the medical line item and 25% are allocated to the surgical line item. When there are no matching surgical line items, claims are allocated to the medical treatment line items based on the number of lines with matching ICD9 codes. In most cases that have no matching surgical treatment, no additional allocation of claims is required.
Inpatient hospital, Outpatient hospital billed without HCPCs	001-779, V01-V82, except those listed under initial diagnosis	Any	Based on the number of line items with matching ICD9 codes. When more than one line item contains the same ICD9 codes, claims are allocated based on the percentage of total dollars for the ICD9 code represented by each line item. This allocation is done after all other claims have been allocated.
Prescription Drugs	Not Applicable	National Drug Codes	Allocated based on percentage of total per capita cost made up by prescription drugs by eligibility category. Mental Health and Chemical Dependency drugs are allocated only to Mental Health and Chemical Dependency lines.

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Exhibit 12-A

Per Capita Cost at Various Thresholds Managed Care Enrollee Costs (Including FCHP FFS)

Threshold	Physical Health		Dental		Mental Health		Total FCHP	
	Percent of Total Cost	Average Per Capita Cost	Percent of Total Cost	Average Per Capita Cost	Percent of Total Cost	Average Per Capita Cost	Percent of Total Cost	Average Per Capita Cost
317	79.6%	\$247.00	30.9%	\$7.09	88.6%	\$26.84	77.3%	\$280.92
347	81.8%	\$253.74	30.9%	\$7.09	89.5%	\$27.10	79.2%	\$287.93
377	86.0%	\$266.83	48.0%	\$11.02	92.0%	\$27.85	84.1%	\$305.70
407	87.0%	\$270.12	48.0%	\$11.02	92.4%	\$27.98	85.0%	\$309.11
437	88.9%	\$275.91	48.0%	\$11.02	97.4%	\$29.49	87.0%	\$316.42
467	93.0%	\$288.52	48.0%	\$11.02	99.8%	\$30.21	90.7%	\$329.74
497	95.4%	\$296.00	48.0%	\$11.02	99.8%	\$30.21	92.7%	\$337.22
527	98.0%	\$304.24	98.8%	\$22.67	99.8%	\$30.23	98.2%	\$357.14
557	99.5%	\$308.70	100.0%	\$22.94	100.0%	\$30.27	99.5%	\$361.92
100% Funding	100.0%	\$310.38	100.0%	\$22.94	100.0%	\$30.27	100.0%	\$363.60

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Exhibit 12-B

Per Capita Cost at Various Thresholds Fee For Service Costs

Threshold	Physical Health		Dental		Mental Health		Total FFS/PCCM	
	Percent of Total Cost	Average Per Capita Cost	Percent of Total Cost	Average Per Capita Cost	Percent of Total Cost	Average Per Capita Cost	Percent of Total Cost	Average Per Capita Cost
317	77.6%	\$200.17	41.9%	\$0.42	90.6%	\$10.91	78.1%	\$211.50
347	79.7%	\$205.58	41.9%	\$0.42	91.1%	\$10.98	80.1%	\$216.98
377	83.5%	\$215.33	64.6%	\$0.64	93.5%	\$11.27	83.9%	\$227.24
407	84.5%	\$218.01	64.6%	\$0.64	94.1%	\$11.34	84.9%	\$229.99
437	85.9%	\$221.44	64.6%	\$0.64	97.3%	\$11.72	86.3%	\$233.80
467	94.8%	\$244.32	64.6%	\$0.64	99.9%	\$12.04	94.9%	\$257.00
497	96.9%	\$249.96	64.6%	\$0.64	99.9%	\$12.04	97.0%	\$262.64
527	98.7%	\$254.48	99.3%	\$0.98	100.0%	\$12.04	98.7%	\$267.51
557	99.7%	\$257.04	100.0%	\$0.99	100.0%	\$12.05	99.7%	\$270.08
100% Funding	100.0%	\$257.85	100.0%	\$0.99	100.0%	\$12.05	100.0%	\$270.89

OREGON HEALTH PLAN: MEDICAID DEMONSTRATION

Exhibit 12-C

Per Capita Cost at Various Thresholds Total Costs

Threshold	Physical Health		Dental		Mental Health		Grand Total	
	Percent of Total Cost	Average Per Capita Cost	Percent of Total Cost	Average Per Capita Cost	Percent of Total Cost	Average Per Capita Cost	Percent of Total Cost	Average Per Capita Cost
317	78.9%	\$229.27	31.0%	\$5.96	88.8%	\$23.35	77.0%	\$258.58
347	81.1%	\$235.51	31.0%	\$5.96	89.7%	\$23.57	78.9%	\$265.03
377	85.1%	\$247.33	48.2%	\$9.26	92.2%	\$24.22	83.6%	\$280.81
407	86.2%	\$250.39	48.2%	\$9.26	92.6%	\$24.34	84.5%	\$283.99
437	87.9%	\$255.28	48.2%	\$9.26	97.4%	\$25.60	86.3%	\$290.14
467	93.6%	\$271.78	48.2%	\$9.26	99.8%	\$26.23	91.4%	\$307.27
497	95.9%	\$278.56	48.2%	\$9.26	99.8%	\$26.23	93.5%	\$314.06
527	98.2%	\$285.40	98.8%	\$19.01	99.9%	\$26.24	98.4%	\$330.65
557	99.5%	\$289.14	100.0%	\$19.24	100.0%	\$26.28	99.6%	\$334.66
100% Funding	100.0%	\$290.49	100.0%	\$19.24	100.0%	\$26.28	100.0%	\$336.01