

March 2007

CY 2008–2009  
Benchmark Rate Study  
Oregon Health Plan  
Summary Report

Oregon Health Services Commission  
Office for Oregon Health Policy and Research

**MERCER**

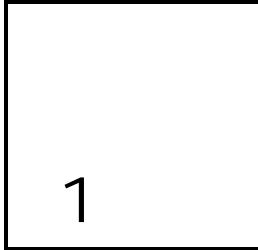
Government Human Services Consulting

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## Preface

### Summary Report

The prior Benchmark Rate Study, State Fiscal Year (SFY) 2006–2007 Benchmark Rates, was comprised of two reports: A Summary Report and a Technical Report. For this Calendar Year (CY) 2008–2009 Benchmark Rate Study, these two reports have been consolidated into this Summary Report.

The current Summary Report is geared toward readers who are primarily interested in the benchmark results at a general level and their related potential policy implications. Readers interested in detailed descriptions of the calculations used in the methodology used to establish benchmark rates should refer to the report Appendices, which, in combination with the prior Benchmark Study and PricewaterhouseCoopers (PWC) September 22, 2006, study *Analysis of Calendar Years 2008–2009 Average Costs*, offer the same level of benchmark rate development transparency provided during the prior study.

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Mercer Government Human Services Consulting (Mercer) extends a sincere thank you to all of the individuals who assisted in the development of the Benchmark Rate Study, including the following:

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## Executive Summary

### Introduction

When the Oregon Health Plan (OHP) was initially implemented, one of the cornerstones of the plan was to increase access to benefits by bringing payments to providers more in line with their costs of providing care. Satisfaction with the OHP ran high with providers and plans during its early years, but declining state revenues have led to a consensus among those providing OHP benefits that payments have not kept up with increasing health care costs. House Bill (HB) 3624, passed during the 2003 legislative session, was seen as an attempt to explicitly quantify how much payments are differing from costs, by setting benchmark rates for the major categories of health care services to which reimbursements can be compared. In addition, these benchmark rates can be used to measure the relative equity of payments among the providers of these services.

HB 3624 charges the Health Services Commission (HSC) to “retain an actuary to determine the benchmark for setting per capita rates necessary to reimburse prepaid managed care health services organizations and fee-for-service (FFS) providers for the cost of providing health services” under OHP. It also specified that these benchmark rates be established for six different service categories. The HSC added several categories, indicated by an asterisk (\*) below, in order to bring additional transparency to the benchmark study results. Summary-level results for the nine major categories of services (COSs) appearing below are presented in the report. Detailed Results by OHP eligibility category for the COSs and the four groupings within the Other Services COS are presented in the Appendices.

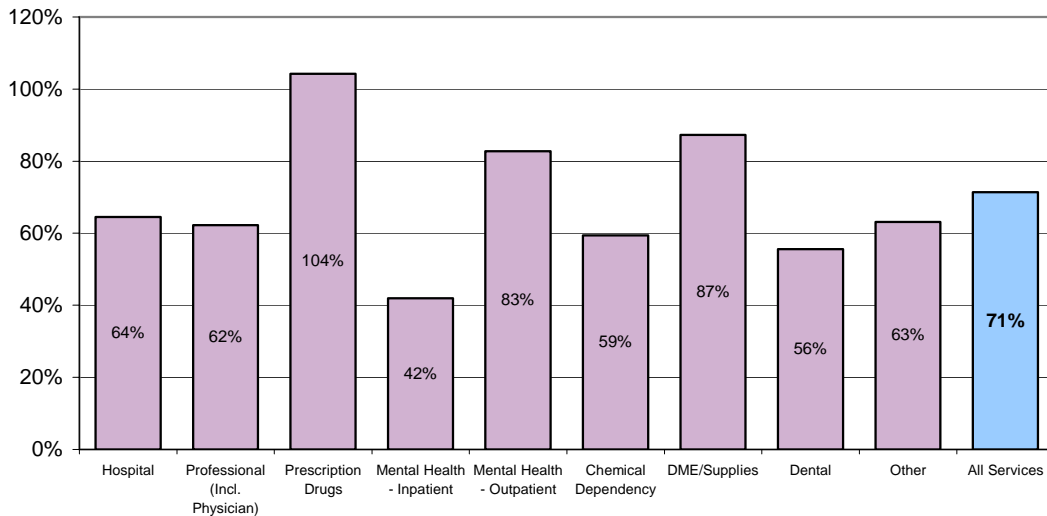
- Hospital Services;
- Professional Services (incl. Physician);
- Prescription Drugs;
- Inpatient Mental Health Services\* ;
- Outpatient Mental Health Services\* ;
- Chemical Dependency Services\* ;
- Durable Medical Equipment/Supplies;
- Dental Services; and
- Other Services, including:
  - Home Health Services\* ;
  - Transportation Services\* ;
  - Vision Services\* ; and
  - Not Elsewhere Classified\*.

## Findings

Figure 2.1 provides a comparison of projected FFS reimbursements to unit cost benchmarks for CY 2008–2009. This figure can be used to determine how best to achieve equity among providers when future funding decisions affecting the OHP are made. The last column in the chart indicates that all service categories could be reimbursed at 71 percent of cost if current resources were redistributed.

This figure represents all fee schedule and policy changes known at the time the study was performed. To the extent that there are any significant fee schedule changes or policy changes made from this point forward that impact the CY 2008–2009 study period, these numbers would change. Significant fee schedule changes have impacted some of the service categories between the historical experience period and the projected study period, particularly for DRG hospitals and outpatient mental health providers.

Figure 2.1: Comparison of CY 2008–2009 Projected FFS Reimbursement to CY 2008–2009 FFS Unit Cost Benchmarks

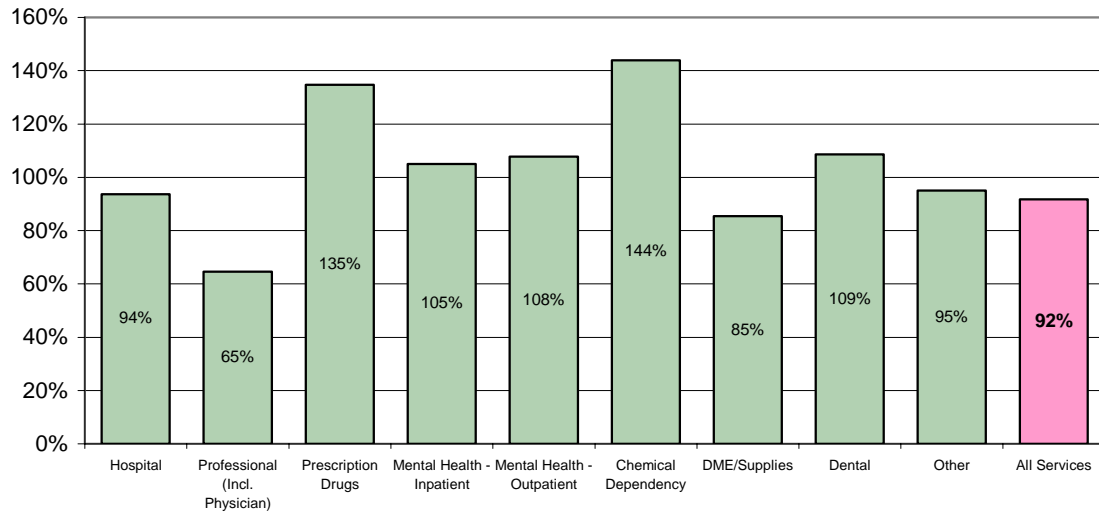


The focus of this study is an evaluation of benchmark rates for the prospective CY 2008–2009 period, providing an overview of expected differences in payments to cost for each of the major provider groups should no action be taken to reduce inequities. Section 4 also provides a review of historical inequities by provider category. Specifically, Figure 4.4 provides a comparison of historical FFS reimbursement to unit cost benchmarks for the current and prior benchmark rate studies.

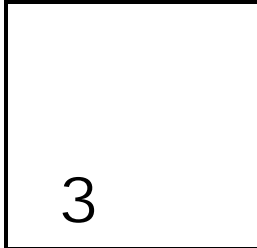
Figure 2.2 provides a comparison of projected managed care unit rates to unit cost benchmarks for CY 2008–2009. The managed care unit rates are the base capitation rates or “Average Costs per Unit of Service”, as summarized from the PWC September 22, 2006, *Analysis of Calendar Years 2008–2009 Average Costs*. Unit rates exclude the load for managed care organization administration costs and vary from unit cost benchmarks for several reasons. Unit rates include assumptions on the managed care organizations’ ability to negotiate lower contract rates, the impact of care management on

the mix of services, and assumptions on rate trends (as opposed to cost trends under cost benchmark development). The last column in the chart indicates that managed care unit rates are approximately 92 percent of cost. To the extent that there are significant policy changes made in the future that will impact the CY 2008–2009 study period, these numbers would change.

Figure 2.2: Comparison of CY 2008–2009 Projected Managed Care Unit Rates to CY 2008–2009 Managed Care Unit Cost Benchmarks



The HSC contracted with Mercer to develop the benchmark rates for the CY 2008–2009 study period. The HSC established the HSC Actuarial Advisory Committee to act as a resource for providing ongoing input into the process. This stakeholder group is made up of knowledgeable representatives from hospitals, physicians, pharmacies, mental health and chemical dependency organizations, the durable medical equipment (DME) industry, dentistry, home health, and the fully-capitated health plans contracted with the OHP. Mercer met with the full Commission and the Advisory Committee twice each during the five-month study period, culminating in the work presented in this report. HB 3624 further directs the Department of Human Services (DHS) to explain any differences between FFS rates and per capita costs for the 2008–2009 biennium and the corresponding benchmark rates to the 74th Oregon Legislative Assembly.



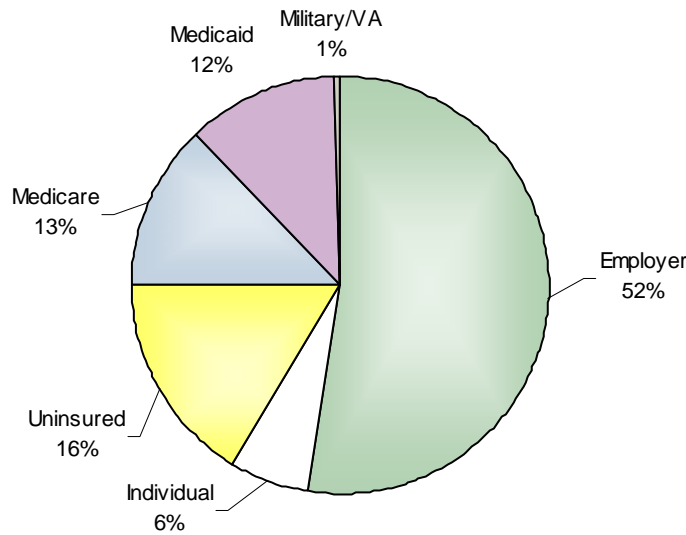
## The Dynamic Health Care Marketplace

It is important to set the context of the report in terms of the current health care marketplace. The double-digit health care premium growth rates over the past decade have revived efforts to bring additional efficiency, equity, and quality of care into health service delivery. Health coverage payers are demanding increased accountability for their investment in health care, but continue to be challenged to sustain current programs. Payers are reconstructing their programs to increase enrollee cost sharing or limit access to care deemed inappropriate, and aggressively challenging provider payment rates. In aggregate, these changes in the marketplace are changing how and from where providers receive their revenue, influencing the delivery and payment of health services.

As major payers, such as Medicare and employer-sponsored programs, make major changes to how health care is paid for and delivered, it is almost a certainty that these changes will have some impact on provider's expectations of Medicaid payments to providers. Moreover, the mix of payers continues to change in Oregon, which further contributes to this dynamic marketplace. As illustrated in Figure 3.1, employers cover 52 percent of the Oregon population for their health care services (down from 56 percent in 2001–2002). An additional 6 percent of Oregonians have individual insurance (down from 7 percent), for a total of 58 percent of the population covered through the commercial market. Employer coverage is declining, as employees are finding coverage unaffordable or no longer offered. Medicare covers 13 percent of the State's population (up from 11 percent) and will continue to increase, given the aging resident population. Changes to commercial and Medicare coverage affect the number of Oregonians with un- or under-served health care needs, impacting Medicaid and its providers and likely increasing the strain on Medicaid reimbursement to providers. While the proportion of low-income Oregonians has remained constant at 12 percent, the rate of uninsurance in the State has increased from 14 percent to 16 percent over this period.

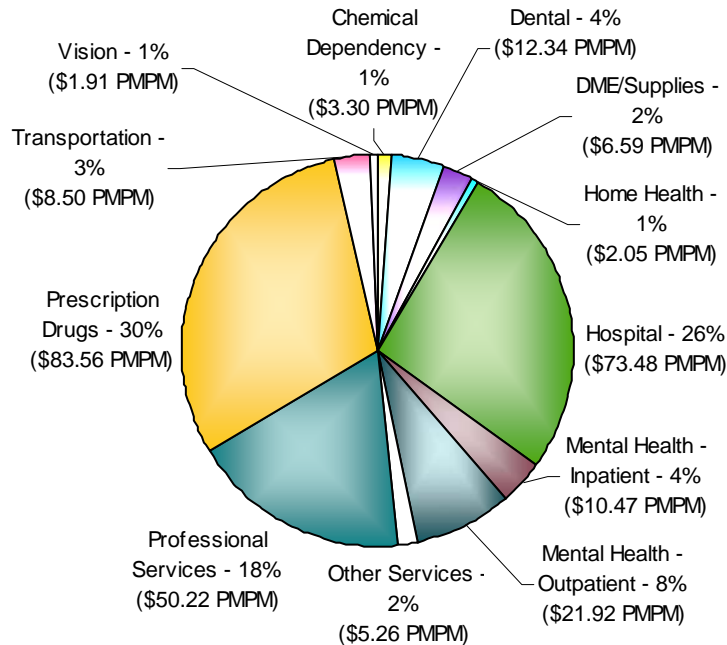


Figure 3.1: Payer Sources in Oregon: 2004–2005



Health care spending by service category in OHP is estimated to be distributed as illustrated in Figure 3.2. This figure is the aggregation of FFS plus managed care capitation payments, with assumptions applied to distribute the capitation payments to the various service categories. This distribution is shown as both a percentage of total spending and as the amount spent on average for services in a category per member per month (PMPM). Some service categories have experienced increases in their percent of total OHP spending since 2002; Prescription Drugs have increased from 29 to 30 percent and Mental Health–Inpatient has increased from 2 to 4 percent. Other service categories have experienced decreases in their percent of total OHP spending; Professional Services has decreased from 19 to 18 percent and Dental has decreased from 6 to 4 percent. The Dental decrease was largely due to the reduction in benefits for the OHP Standard population.

Figure 3.2: 2004 Health Care Spending for OHP (FFS and Managed Care)



## Current Environmental Factors

Stakeholders and others involved in this process stressed the importance of the environmental factors that shape the current health care landscape and serve to explain some of the results reported in this study. A listing of some of these factors unique to the various service categories appears below.

### Hospital

- Low number of hospital beds per person compared to other states;
- Health care delivery initiatives on quality;
- Nurse staffing shortages; and
- Growth in outpatient and emergency room visits.

### Professional Services

- Population growth outpacing physician workforce increases;
- Quality and performance initiatives that impact reimbursement;
- Projected pay cuts for Medicare services through 2012;
- Increases in medical malpractice insurance rates, particularly for some specialty groups; and
- Medically-underserved rural areas.

## Prescription Drugs

- Aging workforce;
- Increasing drug utilization and rising unit costs leading to double-digit trend rates for the near future;
- Increased utilization of high-cost specialty drugs;
- Direct-to-consumer advertising is leading to higher patient demand, particularly in the area of “lifestyle” drugs (e.g., medications to prevent heartburn, osteoporosis); and
- Manufacturers focus on “me-too” drugs (e.g., cholesterol lowering agents, antidepressants), which look to shift market share rather than fill a new need.

## Mental Health

- National trends showing declining reimbursement for mental health services; and
- Legislation calling for at least 75 percent of future services to follow evidence-based practices by 2009.

## DME/Supplies

- Medicare reimbursement rates frozen at current level until 2008; and
- Medicare opening up some DME/Supplies for competitive bid.

## Dental

- Healthy provider participation rate in OHP compared to Medicaid programs in other states.

Additional environmental factors, which likely continue to exist, have been noted in Mercer’s *SFY 2006–2007 Benchmark Rate Study—Oregon Health Plan: Technical Report, November 29, 2004*.

## 4

## Methodology and Results

### Methodology

The initial goal of the HSC was to use a common measuring tool across all COS in establishing the benchmark rates called for by HB 3624. Such a methodology would need to rely on the use of the same type of data for all service categories. Unfortunately, there was no single data source that provided cost data for all of the categories of service. A total of four different approaches were developed that take advantage of the best information available for each COS. They are used in developing the benchmark rates according to the following hierarchy, depending on the data obtainable for each COS, as indicated:

- The **Provider Cost Data Approach** was used when OHP-specific cost data was available, such as hospital cost reports (i.e., Hospital, Mental Health Inpatient, Mental Health Outpatient, and Chemical Dependency.).
- The **Alternative Fee Schedule Approach** was employed if the available cost data was not specific to OHP. Here, an existing commercial or Medicare fee schedule was modified to develop a fee schedule that approximates cost of service (i.e., Prescription Drugs, DME, Dental, Other Services: Ambulatory Transportation, Home Health Care, and Vision.).
- The **Average Market Reimbursement Approach** was used when cost data was unavailable and services were covered by Medicaid, Medicare, and commercial plans. The approach used the average reimbursement received from the three major payer sources as a proxy of cost. This assumes that market forces are at work so that this reimbursement level is just adequate enough to cover costs to the provider (i.e., Professional Services).
- When no cost information was available and Medicaid was a disproportionate payer source or the sole source for a service category, the **Modified Medicaid Data Approach** was used. Here an adjustment was made to OHP FFS reimbursements to approximate provider costs (i.e., Other Services: Other Transportation, Not Elsewhere Classified.).

It should be noted that this report marks the first time that true benchmark rates were developed for the Prescription Drug COS. In Mercer’s opinion, Average Manufacturer Price (AMP) is the best available cost pricing tool available, providing an opportunity to develop cost benchmarks for the Prescription Drugs COS during this benchmark study. This approach is reviewed in Appendix C. AMP information was not available at the time of the previous study and the 2006–2007 “benchmark rates” reflected better practicing approaches employed by other states. Please see *SFY 2006–2007 Benchmark Rate Study: Technical Report* for a full discussion of the previous methodology.

Benchmark rates for FFS and managed care were derived using the aforementioned four methods for the historical experience data period (July 1, 2003 through June 30, 2005, for the OHP Plus population and CY 2005 for the OHP Standard population, herein referred to as “2004”, the midpoint of the OHP Plus data period, which accounts for over 70 percent of the expenditures). The historical unit cost benchmarks represent an approximation of the provider’s cost to supply the service, less an estimate of copayments and the amount paid by other payer sources (e.g., Medicare, worker’s compensation)—in other words, the portion of the cost of care that the State is responsible for.

Mercer reviewed the policy changes in Exhibits 6-A through 6-N of PWC’s *Analysis of Calendar Year 2008–2009 Average Costs, September 22, 2006*, and policy changes in the DHS Actuarial Services Unit’s *Issues Related to Per Capita Costs for 2007–2009, May 24, 2006*. Of the changes in these reports, policy changes that are not noted in the appendices were determined to not have a material impact on the projection of the historical cost benchmarks to CY 2008–2009.

The historical experience timeframe corresponds to the dates for which the most recent OHP historical data was available. As previously discussed, some benchmarking approaches used this historical Medicaid experience as a data source. Establishing benchmark rates for this historical period also allows for comparisons to be made to historical reimbursements over the same time period.

Finally, benchmark rates were calculated for the study period CY 2008–2009. Mercer used CY 2008–2009 as the study period rather than SFY 2008–2009, as directed in the statute, as this six-month shift of the study period allows for easier comparison of this study to PWC’s September 22, 2006, *Analysis of Calendar Years 2008–2009 Average Costs*. Adjustments were made to the historical benchmark rates to account for inflationary cost increases, utilization trends, and policy changes implemented after July 1, 2003. Please refer to the Appendices for a listing of more significant adjustments, and refer to the narrative and Exhibit 6 of PWC’s September 22, 2006, *Analysis of Calendar Years 2008–2009 Average Costs* for additional information regarding these policy changes.

Before examining the unit cost benchmarks for the service categories, some understanding of the units of service represented in the underlying data is necessary. It should be noted that the historical data included variation in the definition of units within

service categories. Figure 4.1 lists the various units represented within each category. While the number of admissions, days, or scripts filled follows a standard definition, a claim could include a month’s worth of visits to a provider or a single one. Examples for the other types of units can be just as striking; “services” for the Professional Services COS could represent the number of lab tests or surgical procedures performed and “CPT code units” for the DME/Supplies COS could represent the number of packages, including 50 syringes or 500 syringes. Costs given on a per unit basis in this report in which a COS contains multiple units of service should therefore be interpreted with caution, as should comparisons of costs on a per unit basis between the current and prior benchmark rate studies. While these numbers are valid for the comparative purposes for which this study is intended, they have limited value in isolation since the blended unit of service has little meaning. It is suggested that industry standards for units of service be considered when performing future rate-setting exercises for OHP.

Figure 4.1: Units of Service Represented in the Historical Medicaid Data by Category of Service

Category of Service (COS)	Type of Unit
Hospital	Admits/Claims
Professional Services	Claims/CPT Code Units/Visits/Services
Prescription Drugs	Claims/Scripts Filled
Mental Health Inpatient	Days/Services
Mental Health Outpatient	Claims/Services
Chemical Dependency	Services
DME/Supplies	HCPSCS/CPT Code Units/Services
Dental	Services
Home Health	Claims
Transportation	Services
Vision	HCPSCS/CPT Code Units
Other Services	Admits/Claims/Services

## Fee-for-Service Results

Figure 4.2 provides a summary of the results related to the FFS unit cost by service category. The first column shows the 2004 FFS historical reimbursement rate derived from the historical Medicaid data set described in the methodology section discussed earlier. The second column gives the 2004 FFS unit cost benchmark for each COS using one of the four approaches also described in the methodology section. The third column provides projected FFS reimbursement from the PWC per capita report. The fourth and final column provides the CY 2008–2009 FFS unit cost benchmark for each service category. In all instances, these costs represent the projection of the 2004 FFS unit cost benchmark forward to the midpoint of CY 2008–2009. The differences in the two benchmarks represent the net total of adjustments for trend and program changes. Significant fee schedule changes have impacted DRG hospitals and outpatient mental

health providers (Appendices A and E). Please also refer to Appendices A through I for discussions on trend adjustments, program changes, and fee schedule changes for each COS, when applicable.

Figure 4.2: FFS Unit Cost Benchmarks by Category of Service

Category of Service (COS)	2004 Medicaid FFS Reimbursement	2004 Unit Cost Benchmark	CY 2008–2009 Projected Medicaid FFS Reimbursement	CY 2008–2009 Unit Cost Benchmark
Hospital	\$ 362.71	\$ 550.19	\$ 413.30	\$ 612.95
Professional Services	\$ 63.51	\$ 95.61	\$ 64.56	\$ 105.77
Prescription Drugs	\$ 58.97	\$ 58.40	\$ 71.07	\$ 77.58
Mental Health Inpatient	\$ 435.87	\$ 847.80	\$ 429.24	\$ 1,103.00
Mental Health Outpatient	\$ 107.80	\$ 113.30	\$ 112.95	\$ 136.55
Chemical Dependency	\$ 36.53	\$ 56.69	\$ 39.95	\$ 67.20
DME/Supplies	\$ 1.56	\$ 1.69	\$ 1.62	\$ 1.88
Dental	\$ 35.56	\$ 52.35	\$ 36.72	\$ 63.10
Other Services	\$ 44.02	\$ 53.93	\$ 37.77	\$ 59.83
<b>All Services</b>	<b>\$ 27.44</b>	<b>\$ 35.93</b>	<b>\$ 26.08</b>	<b>\$ 40.17</b>

Figure 4.3 provides a comparison of projected FFS reimbursements to unit cost benchmarks for CY 2008–2009. This figure can be used to determine how best to achieve equity among providers when future funding decisions affecting OHP are made. The last column in the chart indicates that all service categories would be reimbursed at 71 percent of cost if current resources were redistributed.

This figure represents all fee schedule and policy changes known at the time the study was performed. To the extent that there are any significant fee schedule changes or policy changes made from this point forward that impact the CY 2008–2009 study period, these numbers would change.

Figure 4.3: Comparison of CY 2008–2009 Projected FFS Reimbursement to CY 2008–2009 FFS Unit Cost Benchmarks

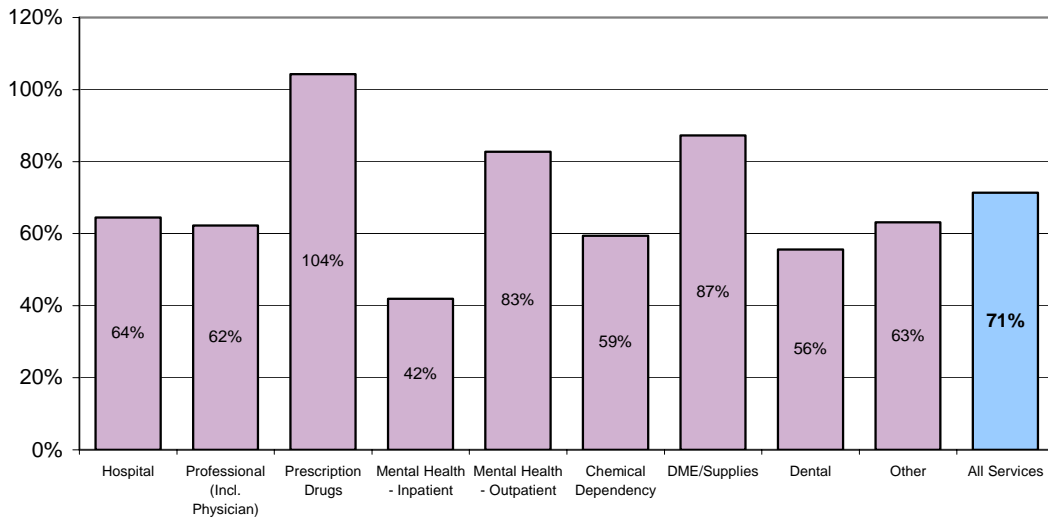
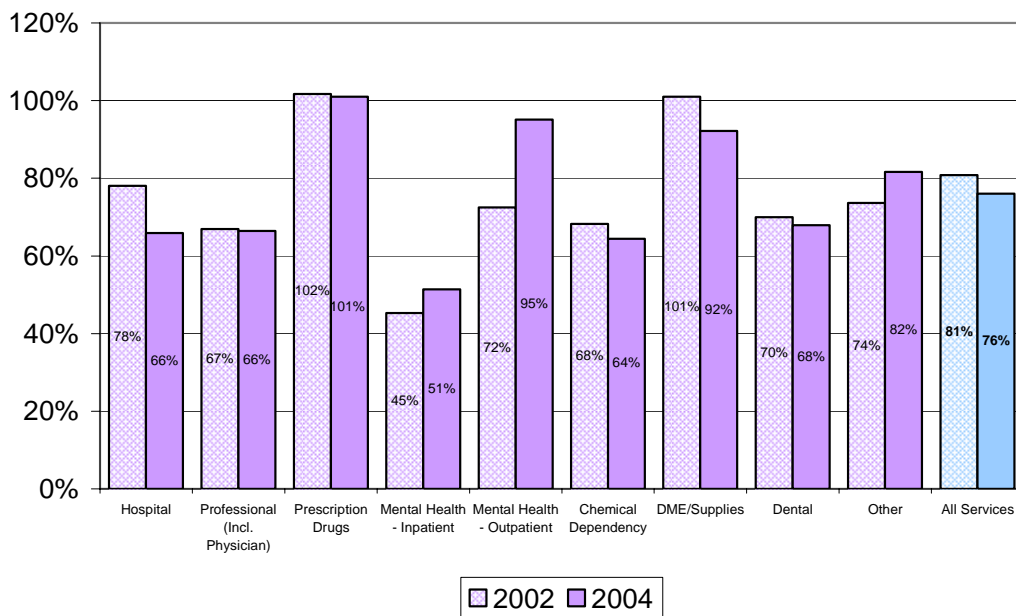


Figure 4.4 provides a comparison of FFS reimbursements to unit cost benchmarks during the historical data periods of the prior and current studies, (i.e., 2002 versus 2004). The figure allows high-level conclusions about the equity of historical reimbursement as a percentage of provider cost over the two historical study periods.

Figure 4.4: Comparison of Historical FFS Reimbursement to Historical FFS Unit Cost Benchmarks





## Managed Care Results

Figure 4.5 shows the summary of results for the managed care unit cost benchmarks. The 2004 managed care unit cost benchmark appears in the second column. CY 2008–2009 unit rates are provided in column three. The managed care unit rates are the base capitation rates or “Average Costs per Unit of Service”, as summarized from PWC’s September 22, 2006, *Analysis of Calendar Years 2008–2009 Average Costs*. A projection of the unit cost benchmark to the study period in a similar manner to that just described for the CY 2008–2009 FFS benchmarks results in the CY 2008–2009 managed care unit cost benchmark, and appears in the fourth column of the figure.

It is strongly suggested that comparisons not be made between the FFS and managed care benchmarks. Unit costs can differ based on the mix of services provided in each setting and variations in reporting. First, delivery systems may differ in case mix severity. In addition, just as there is a variation in units of service and/or types of units within a service category, there are also variations in the way reporting of units occur between delivery systems. If the same service is usually billed in 15 minute increments for FFS and 1 hour increments at the request of a MCO, the unit cost for managed care would be artificially inflated. Finally, and most importantly, unit costs do not reflect utilization or the total cost of care. As such, the provider services with higher unit costs could have lower total costs for that category or vice versa. This could be true if one delivery system saw a significantly smaller number of (on average) more expensive cases than the other.

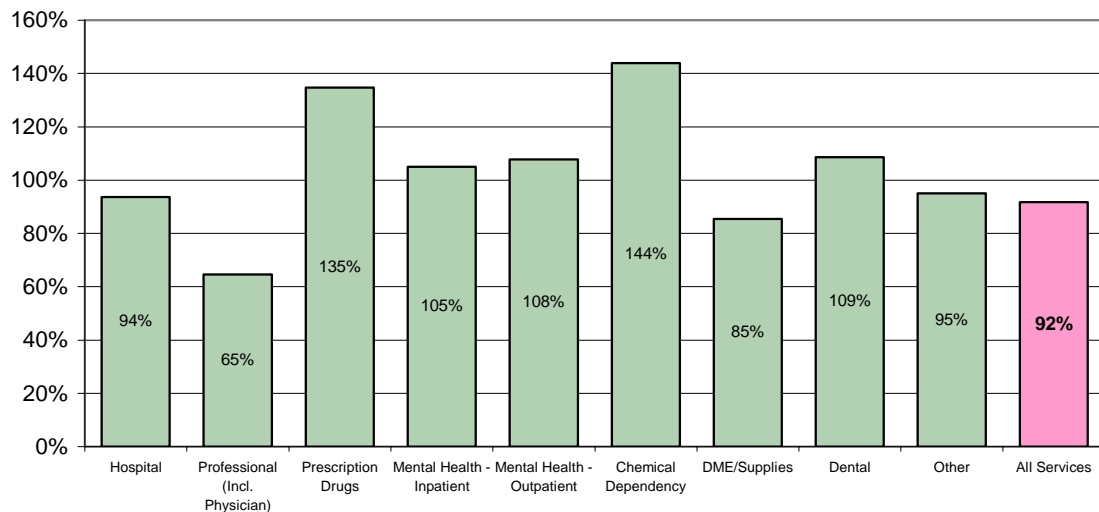
Figure 4.5: Managed Care Unit Cost Benchmarks by Category of Service

Category of Service (COS)	2004 Unit Cost Benchmark	CY 2008-2009 Managed Care Unit Rates	CY 2008–2009 Managed Care Unit Cost Benchmark
Hospital	\$ 418.61	\$ 452.77	\$ 483.31
Professional Services	\$ 82.67 <sup>1</sup>	\$ 59.98	\$ 92.79
Prescription Drugs	\$ 25.93	\$ 41.31	\$ 30.68
Mental Health Inpatient	\$ 178.48	\$ 226.98	\$ 216.26
Mental Health Outpatient	\$ 77.39	\$ 96.37	\$ 89.40
Chemical Dependency	\$ 29.34	\$ 48.69	\$ 33.83
DME/Supplies	\$ 1.94	\$ 1.89	\$ 2.22
Dental	\$ 51.17	\$ 68.03	\$ 62.60
Other Services	\$ 86.82	\$ 93.89	\$ 98.74
<b>All Services</b>	<b>\$ 45.93</b>	<b>\$ 49.01</b>	<b>\$ 53.43</b>

<sup>1</sup> This 2004 FFS unit cost benchmark for Professional Services converts to an approximate amount of \$39.06 per relative value unit (RVU), up from \$38.78 in 2002. This compares to the current FFS RVU conversion factor of \$25.95, which has not changed in seven years.

Figure 4.6 provides a comparison of the projected managed care unit rates to unit cost benchmarks for CY 2008–2009. Unit rates vary from unit cost benchmarks because of several differences in the methodologies to develop unit rates and to develop unit cost benchmarks. The methodology used to develop MCO unit rates considers the MCOs' ability to negotiate lower contract rates, the impact of care management on the mix of services, and assumptions on rate increases necessary to contract with targeted providers in the prospective contract period. Trend assumptions also vary by methodology, with unit cost benchmarks relying on projected cost increases and unit rates relying on projected market reimbursement increases. The last column in the chart indicates that managed care unit rates are approximately 92 percent of cost. To the extent that there are significant policy changes made in the future that impact the CY 2008–2009 study period, these numbers would change.

Figure 4.6: Comparison of CY 2008–2009 Projected Managed Care Unit Rates to CY 2008–2009 Managed Care Unit Cost Benchmarks



A chart similar to Figure 4.4, comparing 2004 managed care billed charges to the 2004 unit cost benchmarks was not performed as the results would compare billed charges to cost benchmarks. Having information on the amounts actually paid by the managed care plans to their providers would show which sectors are fairing better than others, but this data is considered proprietary and was not available.

## Study Notes

All of the numbers shown are for the total OHP population (OHP Plus and OHP Standard). Breakouts for each COS by OHP eligibility group (e.g., Chemical Dependency: OHP Adults and Couples, Dental: Old Age Assistance with Medicare) can be found in the Appendices. Stakeholder input directed that these rates represent statewide unit cost benchmarks. Please be aware that variation by such factors as geographic region, provider setting, and individual facility will likely occur.

It is important to note that values used in making these calculations represent a point estimate within a range of acceptable values. Ranges vary by service category based on the availability of data, with larger ranges for services for which data sources were lower in the methodology hierarchy discussed at the beginning of this section. Ranges also increase with the number of necessary assumptions, e.g., the 2008–2009 benchmarks for those service categories impacted by policy changes have wider ranges for values than the 2004 benchmarks and those service categories with no policy change adjustments. Various assumptions were necessary when producing these results and are disclosed in the Appendices. Other cautions should be noted when examining the benchmark rates given the limitations of the data available and the scope of the project (see Appendices and the *SFY 2006–2007 Benchmark Rate Study: Technical Report* for a complete discussion of the limitations associated with this study). Also, these benchmark rates should not be viewed as rates that can be used to set reimbursement under OHP. As these rates are meant to represent the cost of care, they are not consistent with the CMS requirements for capitation rate development under Medicaid (i.e., what can reasonably be paid to an effectively and efficiently run managed care plan).

HB 3624 directs DHS to submit a report to the 74<sup>th</sup> Oregon Legislative Assembly. Their report is to compare the rates on which the OHP's budget is based for the 2008–2009 biennium and the benchmark rates contained in this report. Differences in rates are to be disclosed with both the amount and reason for any variances given.

## Appendix A

## Hospital Benchmark Rate Development

### Approach: Cost-Adjusted Detailed Claims Data

Mercer’s approach involved adjusting fee-for-service (FFS) facility-level utilization and reimbursement data and managed care billed charges data that had been adjusted by cost-to-charge ratios (CCRs)

#### Additional Data Sets

Medicaid cost report CCRs by facility, as provided by the DHS Actuarial Services Unit supplied procedure-level data for:

- OHP Standard (Incurred January 1, 2005–December 31, 2005); and
- OHP Plus (Incurred July 1, 2003–June 30, 2005).

#### Data Adjustments

Description of Adjustment Factor	Adjustment Factor
<b>Unit cost trend factor:</b> Annualized factor to trend benchmark cost per unit to projected study period of CY 2008–2009	+ 5.0%

#### Notes:

1. Annualized utilization trend factors to trend utilization per member to the projected study period of CY 2008-2009 were taken directly from the PWC September 22, 2006, *Analysis of Calendar Years 2008–2009 Average Costs*.
2. CCRs were used to derive benchmarks. It should be noted that the data time periods used in developing the CCRs for individual hospitals reflect a different period than included in the base data. In most cases, the data for specific hospitals to derive CCRs was found to overlap with the time period of the benchmarking base data. However, for the purpose of this report, no adjustment was made to factor in these timing differences.
3. Payment to cost factors were derived for Medicare payments for the dual populations (AB/AD with Medicare and OAA with Medicare). Dual population data was adjusted to reflect the outcome of the non-dual population categories. Medicare is the primary payer for duals and this adjustment prevented Medicare enrollee charge data from having an unwarranted impact on benchmark calculations.

4. Payment to cost factors were adjusted for third-party liability (TPL) payments other than Medicare. These reduction percentages vary by eligibility, for both inpatient and outpatient data, and were the same percentages used in Mercer's prior study. The effect for all FFS inpatient and outpatient data was a reduction of the overall factor by 3.5 percent.
5. Payment to cost factors were adjusted for copayment amounts. The reduction only applied to the FFS outpatient data, which was reduced by 0.2 percent. The overall effect for all FFS inpatient and outpatient data was a reduction of the overall factor by 0.1 percent.
6. DRG hospital FFS reimbursement changed to 80 percent of the Medicare Unit Value (MUV) effective March 1, 2004 and increased to 100 percent of the MUV effective August 15, 2005. Other fee schedule changes occurred prior to March 2004, with limited impact on study results.
7. Payment to cost factors were adjusted for assessment and capital funding. The overall effect for FFS inpatient was 2.8 percent.
8. The data from hospitals with CCRs represented approximately 91 percent of inpatient dollars and 78 percent of outpatient dollars. Data attributed to facilities that did not have a CCR were adjusted based on the average conversion factor, and assumes similar cost provisions would be applicable to these institutions.

Hospital

Fee-for-Service Eligibility Category	Unadjusted Historical Experience <sup>1</sup>			Adjusted Historical Experience <sup>2</sup>			Historical Benchmark Rates			CY 2008-09 Benchmark Rates		
	Reimbursement per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Reimbursement per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>
AB/AD without Medicare	\$ 467.15	8.2124	\$ 319.70	\$ 467.68	8.2293	\$ 320.72	\$ 831.11	8.2293	\$ 569.95	\$ 948.95	11.1970	\$ 885.45
AB/AD with Medicare	\$ 157.25	2.1062	\$ 27.60	\$ 157.56	2.1638	\$ 28.41	\$ 117.40	2.1638	\$ 21.17	\$ 138.46	3.2283	\$ 37.25
CAWEM	\$ 1,923.43	0.3370	\$ 54.01	\$ 1,924.65	0.3384	\$ 54.28	\$ 3,327.01	0.3384	\$ 93.83	\$ 4,233.31	0.3384	\$ 119.39
PLM/CHIP/TANF <1	\$ 982.40	5.6464	\$ 462.25	\$ 983.57	5.6615	\$ 464.04	\$ 1,333.62	5.6615	\$ 629.19	\$ 1,632.35	7.1702	\$ 975.36
PLM/CHIP/TANF 1 - 5	\$ 166.31	2.0694	\$ 28.68	\$ 166.40	2.0611	\$ 28.58	\$ 217.58	2.0611	\$ 37.37	\$ 246.06	2.6579	\$ 54.50
PLM/CHIP/TANF 6 - 18	\$ 186.85	1.7045	\$ 26.54	\$ 186.94	1.7011	\$ 26.50	\$ 256.42	1.7011	\$ 36.35	\$ 294.24	2.1937	\$ 53.79
OAA without Medicare	\$ 463.94	4.3299	\$ 167.40	\$ 464.49	4.3346	\$ 167.78	\$ 1,249.26	4.3346	\$ 451.25	\$ 1,429.58	5.8875	\$ 701.39
OAA with Medicare	\$ 215.09	1.1180	\$ 20.04	\$ 216.77	1.1520	\$ 20.81	\$ 253.95	1.1520	\$ 24.38	\$ 291.92	1.6940	\$ 41.21
OHP Adults & Couples	\$ 223.45	8.0077	\$ 149.11	\$ 223.27	8.0396	\$ 149.58	\$ 313.29	8.0396	\$ 209.89	\$ 338.62	10.3313	\$ 291.53
OHP Families	\$ 171.02	4.7673	\$ 67.94	\$ 170.91	4.7863	\$ 68.17	\$ 220.21	4.7863	\$ 87.83	\$ 224.19	5.6603	\$ 105.75
PLM Adults	\$ 346.21	9.9932	\$ 288.31	\$ 346.60	10.0353	\$ 289.85	\$ 526.25	10.0353	\$ 440.09	\$ 512.55	12.2264	\$ 522.22
SCF Children	\$ 276.78	1.7672	\$ 40.76	\$ 277.04	1.7690	\$ 40.84	\$ 384.42	1.7690	\$ 56.67	\$ 452.91	2.2802	\$ 86.06
TANF Adults	\$ 214.08	7.0410	\$ 125.61	\$ 214.25	7.0413	\$ 125.72	\$ 286.39	7.0413	\$ 168.05	\$ 283.31	8.7988	\$ 207.73
Hospital Total	\$ 362.49	2.9245	\$ 88.34	\$ 362.71	2.9358	\$ 88.74	\$ 550.19	2.9358	\$ 134.60	\$ 612.95	3.8343	\$ 195.85

<sup>1</sup>Unadjusted historical experience: July 2003 through June 2005 for OHP Plus and CY 2005 for OHP Standard, based on Exhibits 3, 4, and 5 of PricewaterhouseCoopers "Analysis of Calendar Years 2008 - 2009 Average Costs," dated September 22, 2006.

<sup>2</sup>Adjusted Historical Experience: Historical experience after the application of appropriate adjustments to the historical experience, e.g., claims completion factors and historical policy change adjustments. These adjustments are noted in the related category of service Appendix.

<sup>3</sup>Utilization per member (UPM): Units of service per member per year. UPM is calculated as total units divided by total member months, multiplied by 12.

<sup>4</sup>Per member per month (PMPM): Monthly reimbursement/cost per member per month. The PMPM value is calculated as reimbursement/cost per unit multiplied times UPM and divided by 12.

Unit type(s) for the Hospital category of service: Admits or Claims.  
Sum of numbers may differ from totals due to rounding.

Managed Care Eligibility Group	Unadjusted Historical Experience <sup>1</sup>			Adjusted Historical Experience <sup>2</sup>			Historical Benchmark Rates			CY 2008-09 Benchmark Rates		
	Billed per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Billed per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>
AB/AD without Medicare	\$ 1,115.67	6.2629	\$ 582.28	\$ 1,115.05	6.3000	\$ 585.40	\$ 609.83	6.3000	\$ 320.16	\$ 769.69	7.4873	\$ 480.24
AB/AD with Medicare	\$ 1,312.08	4.5443	\$ 496.87	\$ 200.38	4.5849	\$ 76.56	\$ 102.86	4.5849	\$ 39.30	\$ 118.57	5.5888	\$ 55.22
CAWEM	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -
PLM/CHIP/TANF <1	\$ 1,498.71	3.6049	\$ 450.23	\$ 1,497.72	3.6257	\$ 452.52	\$ 840.14	3.6257	\$ 253.84	\$ 889.96	4.3867	\$ 325.33
PLM/CHIP/TANF 1 - 5	\$ 424.23	1.7261	\$ 61.02	\$ 424.01	1.7241	\$ 60.92	\$ 208.59	1.7241	\$ 29.97	\$ 237.23	2.1842	\$ 43.18
PLM/CHIP/TANF 6 - 18	\$ 497.44	1.2991	\$ 53.85	\$ 497.31	1.2989	\$ 53.83	\$ 249.26	1.2989	\$ 26.98	\$ 278.61	1.6449	\$ 38.19
OAA without Medicare	\$ 1,533.11	4.2116	\$ 538.07	\$ 1,532.25	4.2280	\$ 539.86	\$ 871.76	4.2280	\$ 307.15	\$ 1,100.44	5.0250	\$ 460.81
OAA with Medicare	\$ 1,805.85	4.1655	\$ 626.85	\$ 245.54	4.2070	\$ 86.08	\$ 132.30	4.2070	\$ 46.38	\$ 150.08	5.0963	\$ 63.74
OHP Adults & Couples	\$ 892.41	4.5559	\$ 338.81	\$ 891.57	4.5739	\$ 339.83	\$ 479.04	4.5739	\$ 182.59	\$ 569.98	5.2619	\$ 249.93
OHP Families	\$ 622.94	2.9475	\$ 153.01	\$ 622.51	2.9592	\$ 153.51	\$ 321.41	2.9592	\$ 79.26	\$ 351.44	2.9484	\$ 86.35
PLM Adults	\$ 1,222.51	9.5769	\$ 975.66	\$ 1,221.74	9.6713	\$ 984.65	\$ 710.34	9.6713	\$ 572.49	\$ 822.96	9.4468	\$ 647.86
SCF Children	\$ 539.91	1.4518	\$ 65.32	\$ 539.75	1.4560	\$ 65.49	\$ 274.12	1.4560	\$ 33.26	\$ 307.71	1.8430	\$ 47.26
TANF Adults	\$ 699.90	4.8257	\$ 281.46	\$ 699.58	4.8543	\$ 283.00	\$ 374.17	4.8543	\$ 151.36	\$ 436.45	4.8055	\$ 174.78
Hospital Total	\$ 956.23	3.1210	\$ 248.70	\$ 771.91	3.1366	\$ 201.76	\$ 418.61	3.1366	\$ 109.42	\$ 483.31	3.6221	\$ 145.88

<sup>1</sup>Unadjusted historical experience: July 2003 through June 2005 for OHP Plus and CY 2005 for OHP Standard, based on Exhibits 3, 4, and 5 of PricewaterhouseCoopers "Analysis of Calendar Years 2008 - 2009 Average Costs," dated September 22, 2006.

<sup>2</sup>Adjusted Historical Experience: Historical experience after the application of appropriate adjustments to the historical experience, e.g., claims completion factors and historical policy change adjustments. These adjustments are noted in the related category of service Appendix.

<sup>3</sup>Utilization per member (UPM): Units of service per member per year. UPM is calculated as total units divided by total member months, multiplied by 12.

<sup>4</sup>Per member per month (PMPM): Monthly billed/cost per member per month. The PMPM value is calculated as billed/cost per unit multiplied times UPM and divided by 12.

Unit type(s) for the Hospital category of service: Admits or Claims.  
Sum of numbers may differ from totals due to rounding.

## Appendix B

## Professional Services Benchmark Rate Development

### Approach: Average Market Reimbursement

Mercer used historical Professional Services data from July 1, 2003 through June 30, 2005, for OHP Plus and January 1, 2005 through December 31, 2005, for OHP Standard to derive cost benchmarks for the period. The Average Market Reimbursement Approach is based on the assumption that total reimbursement for professional services is expected to match provider cost levels.

Historical data was summarized into ten major subcategories of service (e.g., office visits, surgery). Market reimbursement per service rates were calculated based on Medicaid, Medicare, and the commercial sector derived utilization and pricing relationships. These utilization and pricing relationships were used to determine the market reimbursement rates on a cost per service basis for Medicaid, Medicare, and commercial, the different payer sources for providers. These results were blended, based on the different market payer proportions to derive a benchmark unit cost reimbursement. A table showing the different payer mix values used in the blending phase of the calculations is shown below.

The benchmark reflects the outcome of the average market reimbursement valuation analysis of historical Professional Services data for the period. Please refer to Mercer's *SFY 2006–2007 Benchmark Rate Study—Oregon Health Plan: Technical Report, November 29, 2004*, for additional information regarding this approach. Factors and assumptions were reviewed and updated to reflect the time period of the data used in the analysis.

#### Data Adjustments

Description of Adjustment Factor	Adjustment Factor
<b>Unit cost trend factor:</b> Annualized factor to trend benchmark cost per unit to projected study period of CY 2008–2009	+ 3.1%

Assumed Payer Mix<sup>1</sup>

Payer	Fee-for-Service	Managed Care	Total
Medicaid	5.0%	9.0%	13.9%
Medicare	10.6%	4.9%	15.5%
Commercial	40.6%	29.9%	70.6%
<b>Total</b>	<b>56.2%</b>	<b>43.8%</b>	<b>100.0%</b>

*Notes:*

1. Annualized utilization trend factors to trend utilization per member to the projected study period of CY 2008–2009 were taken directly from the PWC September 22, 2006, *Analysis of Calendar Years 2008–2009 Average Costs*.

<sup>1</sup> <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Oregon&category=Health+Coverage+%26+Uninsured&subcategory=Health+Insurance+Status&topic=Total+Population>



Professional Services (incl. Physician)

Fee-for-Service Eligibility Category	Unadjusted Historical Experience <sup>1</sup>			Adjusted Historical Experience <sup>2</sup>			Historical Benchmark Rates			CY 2008-09 Benchmark Rates		
	Reimbursement per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Reimbursement per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>
AB/AD without Medicare	\$ 57.68	27.0717	\$ 130.07	\$ 57.68	27.4498	\$ 131.89	\$ 86.83	27.4498	\$ 198.54	\$ 97.32	32.3448	\$ 262.48
AB/AD with Medicare	\$ 39.70	6.4629	\$ 21.37	\$ 39.70	6.4823	\$ 21.43	\$ 59.76	6.4823	\$ 32.26	\$ 66.97	8.1958	\$ 46.00
CAWEM	\$ 390.11	0.5619	\$ 18.27	\$ 390.11	0.5704	\$ 18.54	\$ 587.25	0.5704	\$ 27.91	\$ 658.19	0.5704	\$ 31.28
PLM/CHIP/TANF <1	\$ 61.25	24.5400	\$ 125.25	\$ 61.25	24.8828	\$ 127.00	\$ 92.20	24.8828	\$ 191.17	\$ 103.33	30.4928	\$ 262.57
PLM/CHIP/TANF 1 - 5	\$ 53.70	7.1460	\$ 31.98	\$ 53.69	7.2023	\$ 32.23	\$ 80.83	7.2023	\$ 48.51	\$ 90.59	8.8261	\$ 66.63
PLM/CHIP/TANF 6 - 18	\$ 55.64	6.6697	\$ 30.80	\$ 55.64	6.7357	\$ 31.10	\$ 83.76	6.7357	\$ 46.82	\$ 93.88	8.2543	\$ 64.44
OAA without Medicare	\$ 54.99	14.3707	\$ 65.86	\$ 54.99	14.5568	\$ 66.71	\$ 82.78	14.5568	\$ 100.42	\$ 92.78	17.1526	\$ 132.90
OAA with Medicare	\$ 40.35	5.3710	\$ 18.06	\$ 40.35	5.3925	\$ 18.13	\$ 60.73	5.3925	\$ 27.29	\$ 68.07	6.8179	\$ 38.95
OHP Adults & Couples	\$ 70.56	18.6023	\$ 109.24	\$ 70.56	18.7883	\$ 110.33	\$ 106.21	18.7883	\$ 166.09	\$ 116.60	21.6258	\$ 210.14
OHP Families	\$ 59.83	12.0535	\$ 59.78	\$ 59.83	12.1740	\$ 60.38	\$ 90.06	12.1740	\$ 90.89	\$ 98.87	14.0336	\$ 115.30
PLM Adults	\$ 91.99	25.4437	\$ 190.97	\$ 91.99	25.8508	\$ 194.02	\$ 138.47	25.8508	\$ 292.07	\$ 155.20	30.5520	\$ 387.16
SCF Children	\$ 71.56	9.9472	\$ 59.31	\$ 71.56	10.0761	\$ 60.07	\$ 107.73	10.0761	\$ 90.43	\$ 120.74	12.3478	\$ 124.35
TANF Adults	\$ 71.31	14.9344	\$ 87.11	\$ 71.31	15.1127	\$ 88.15	\$ 107.34	15.1127	\$ 132.70	\$ 120.31	17.8610	\$ 176.06
Physician Total	\$ 63.47	9.4478	\$ 49.70	\$ 63.51	9.5531	\$ 50.28	\$ 95.61	9.5531	\$ 75.69	\$ 105.77	11.5087	\$ 100.88

<sup>1</sup>Unadjusted historical experience: July 2003 through June 2005 for OHP Plus and CY 2005 for OHP Standard, based on Exhibits 3, 4, and 5 of PricewaterhouseCoopers "Analysis of Calendar Years 2008 - 2009 Average Costs," dated September 22, 2006.

<sup>2</sup>Adjusted Historical Experience: Historical experience after the application of appropriate adjustments to the historical experience, e.g., claims completion factors and historical policy change adjustments. These adjustments are noted in the related category of service Appendix.

<sup>3</sup>Utilization per member (UPM): Units of service per member per year. UPM is calculated as total units divided by total member months, multiplied by 12.

<sup>4</sup>Per member per month (PMPM): Monthly reimbursement/cost per member per month. The PMPM value is calculated as reimbursement/cost per unit multiplied times UPM and divided by 12.

Unit type(s) for the Professional Services category of service: Visits, Services, Claims, or CPT Code Units.  
Sum of numbers may differ from totals due to rounding.

Managed Care Eligibility Group	Unadjusted Historical Experience <sup>1</sup>			Adjusted Historical Experience <sup>2</sup>			Historical Benchmark Rates			CY 2008-09 Benchmark Rates		
	Billed per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Billed per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>
AB/AD without Medicare	\$ 133.99	21.2986	\$ 237.82	\$ 133.99	21.3407	\$ 238.29	\$ 87.10	21.3407	\$ 154.90	\$ 98.13	26.2024	\$ 214.55
AB/AD with Medicare	\$ 153.11	14.5153	\$ 185.20	\$ 29.99	14.6452	\$ 36.60	\$ 10.13	14.6452	\$ 12.36	\$ 11.41	17.5041	\$ 16.93
CAWEM	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -
PLM/CHIP/TANF <1	\$ 91.69	24.2754	\$ 185.48	\$ 91.69	24.3234	\$ 185.85	\$ 87.56	24.3234	\$ 177.48	\$ 98.64	29.4093	\$ 241.76
PLM/CHIP/TANF 1 - 5	\$ 89.11	7.3529	\$ 54.60	\$ 89.11	7.3157	\$ 54.32	\$ 79.06	7.3157	\$ 48.19	\$ 89.06	8.8453	\$ 65.65
PLM/CHIP/TANF 6 - 18	\$ 103.36	4.8050	\$ 41.39	\$ 103.36	4.7854	\$ 41.22	\$ 92.26	4.7854	\$ 36.79	\$ 103.94	5.7861	\$ 50.26
OAA without Medicare	\$ 153.51	19.1116	\$ 244.49	\$ 153.51	19.1109	\$ 244.48	\$ 81.69	19.1109	\$ 130.09	\$ 92.03	23.4646	\$ 180.23
OAA with Medicare	\$ 163.83	15.5481	\$ 212.27	\$ 32.18	15.7029	\$ 42.11	\$ 9.53	15.7029	\$ 12.47	\$ 10.73	18.7683	\$ 17.07
OHP Adults & Couples	\$ 120.71	20.1454	\$ 202.65	\$ 120.71	20.3469	\$ 204.68	\$ 101.10	20.3469	\$ 171.42	\$ 111.50	23.9065	\$ 222.42
OHP Families	\$ 116.14	12.6669	\$ 122.60	\$ 116.14	12.7936	\$ 123.82	\$ 83.84	12.7936	\$ 89.39	\$ 92.47	14.4069	\$ 111.30
PLM Adults	\$ 236.23	28.0285	\$ 551.76	\$ 236.23	28.1967	\$ 555.07	\$ 128.92	28.1967	\$ 302.93	\$ 145.24	32.4948	\$ 393.58
SCF Children	\$ 103.70	8.1922	\$ 70.79	\$ 103.70	8.1836	\$ 70.72	\$ 101.35	8.1836	\$ 69.12	\$ 114.18	9.8948	\$ 94.29
TANF Adults	\$ 136.61	14.4998	\$ 165.07	\$ 136.61	14.5285	\$ 165.40	\$ 101.19	14.5285	\$ 122.51	\$ 114.00	16.7431	\$ 159.34
Physician Total	\$ 127.09	11.7823	\$ 124.78	\$ 110.90	11.8057	\$ 109.10	\$ 82.67	11.8057	\$ 81.33	\$ 92.79	14.1180	\$ 109.17

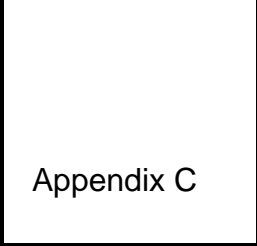
<sup>1</sup>Unadjusted historical experience: July 2003 through June 2005 for OHP Plus and CY 2005 for OHP Standard, based on Exhibits 3, 4, and 5 of PricewaterhouseCoopers "Analysis of Calendar Years 2008 - 2009 Average Costs," dated September 22, 2006.

<sup>2</sup>Adjusted Historical Experience: Historical experience after the application of appropriate adjustments to the historical experience, e.g., claims completion factors and historical policy change adjustments. These adjustments are noted in the related category of service Appendix.

<sup>3</sup>Utilization per member (UPM): Units of service per member per year. UPM is calculated as total units divided by total member months, multiplied by 12.

<sup>4</sup>Per member per month (PMPM): Monthly billed/cost per member per month. The PMPM value is calculated as billed/cost per unit multiplied times UPM and divided by 12.

Unit type(s) for the Professional Services category of service: Visits, Services, Claims, or CPT Code Units.  
Sum of numbers may differ from totals due to rounding.



Appendix C

## Prescription Drugs Benchmark Rate Development

### Approach: Average Manufacturer Price (AMP) Adjusted Cost

Mercer's approach involved a review of summarized National Drug Code (NDC)-level utilization and paid pharmacy claims data provided by the DHS Actuarial Services Unit. The data included FFS data and managed care organization (MCO) data that was repriced using the Actuarial Services Unit's FFS pricing methodology. Mercer compared the reimbursed paid amount to a calculated cost based on an estimated AMP plus a dispensing fee reflective of the actual cost related to the service.

The cost of medication had two components: the ingredient cost of the medication and the cost of the pharmacy to dispense the drug. Mercer chose to use AMP to estimate the ingredient cost of the medication. Other sources of drug pricing, such as First Data Bank's National Drug Data File (NDDF) Average Wholesale Price (AWP), have come under increased scrutiny and do not reflect the actual cost of the drug. The AMP is the average price paid to the manufacturer by wholesalers for drugs dispensed in retail and mail order pharmacies, not including any rebates paid or received. While the AMP may not reflect the actual cost paid to the manufacturer in all cases, it was determined to be the most reflective of actual cost.

The State was not able to provide Mercer with their current AMP price list. To re-price the claims with the AMP price, Mercer relied on the results of a June 2005 study by the Office of Inspector General, *Medicaid Drug Price Comparisons: Average Manufacturer Price to Published Prices*, which compared the NDDF AWP price to the AMP for a selected group of drugs. This study looked at the average percent difference in the AWP and AMP for both brand and generic drugs. While this average discount would not necessarily apply to a specific drug, it was determined that on an aggregate level, as the State's pharmacy data was presented to Mercer, the average discount would apply.

For the dispensing fee, Mercer chose to replace the State's current dispensing fee paid to pharmacies with one that was based on a recently published dispensing fee survey.

Mercer reviewed a number of surveys and chose to use the results from a dispensing fee survey conducted by Myers and Stauffer in 2005 for the State of Indiana, *Analysis of Pharmacy Dispensing Fees for the Indiana Medicaid Program*. This study looked at all the costs involved in dispensing a medication, including labor costs, overhead, and operational costs among other variables.

### Additional Data Sets

- December 2006 AWP pricing pulled from NDDF by NDC; and
- Summarized NDC-level data provided by Oregon, matching the historical base data periods for OHP Standard (CY 2005) and OHP Plus (July 1, 2003-June 30, 2005).

### Data Adjustments

Description of Adjustment Factor	Adjustment Factor
Unit cost trend factor: Annualized factor to trend benchmark cost per unit to projected study period of CY 2008–2009 (annualized)	+ 3.6%

#### Notes:

1. Annualized utilization trend factors to trend utilization per member to the projected study period of CY 2008-2009 were taken directly from the PWC September 22, 2006, *Analysis of Calendar Years 2008–2009 Average Costs*.
2. MCOs and the State both receive rebates directly from manufacturers for selected drugs upon dispensing. Because these rebates are collected after dispensing and payment to the pharmacies, they are not reflected in the pharmacies' cost for dispensing a prescription.
3. The rebate amounts paid by manufacturers to Oregon for FFS prescriptions is much greater than that paid to the MCOs. It was estimated in the PWC report that MCO rebates accounted for approximately 1.4 percent of the drug cost. In contrast, the 2004 CMS-64 reports show the State received approximately 21.96 percent of FFS drug cost back in rebates.
4. For managed care data, the lesser of total billed or total paid was used. This step contributed to adjusting data for mis-pricing due to quantity issues, as paid can never be more than billed.
5. AMP price was calculated on a NDC level at AWP minus 74 percent for generics and AWP minus 24 percent for brands and non-drug medications (e.g., diabetic supplies, compounds). A dispensing fee of \$8.07 per script was added to the calculated AMP cost.
6. For only those claims where the ratio of paid amount to AWP was less than 10 percent, Mercer used the paid amount as the cost benchmark; otherwise the AMP price was used as the cost benchmark. This adjustment was made to adjust for suspected quantity errors in the aggregated data.
7. If the paid amount per claim was less than \$5.00, Mercer used the paid amount as the cost benchmark. This was done to reflect the application of Usual & Customary pricing.
8. For those NDCs that Mercer was unable to obtain an AWP price, Mercer used the paid amount as the cost benchmark.
9. An adjustment was made for Copaxone, Fuzeon, Rocephin, Synagis, Avonex, Zosyn, and Humira. The NDCs associated with these drugs had suspected invalid quantities in the quantity field, so Mercer used the paid amount as the cost benchmark for these selected drugs.
10. In aggregate, all adjustments where the paid amount was used in place of the calculated cost benchmark (as outlined in Notes 4–7 above) applied to a total of 6.8 percent of claims and 2.2 percent of paid dollars. All other claims were calculated using the AMP plus dispensing fee methodology.
11. For the managed care OHP Plus population, mental health and chemical dependency drugs were excluded at the request of the State. These drugs should have been covered under FFS.

12. For the FFS OHP Plus population, copayments were removed in the calculation of the benchmark cost. The copayments are \$2.00 per generic script and \$3.00 per brand script. Copayments affect the following eligibility groups: AB/AD with Medicare, AB/AD without Medicare, CAWEM, OAA with Medicare, OAA without Medicare, and TANF Adults.

Prescription Drugs

Fee-for-Service Eligibility Category	Unadjusted Historical Experience <sup>1</sup>			Adjusted Historical Experience <sup>2</sup>			Historical Benchmark Rates			CY 2008-09 Benchmark Rates		
	Reimbursement per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Reimbursement per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>
AB/AD without Medicare	\$ 84.14	43.2151	\$ 271.52	\$ 84.25	42.7135	\$ 268.64	\$ 84.43	42.7135	\$ 270.90	\$ 97.71	48.2843	\$ 354.20
AB/AD with Medicare	\$ 74.36	65.0143	\$ 352.96	\$ 74.48	64.4690	\$ 350.45	\$ 72.41	64.4690	\$ 342.49	\$ 69.10	2.2172	\$ 11.89
CAWEM	\$ 35.35	0.0008	\$ 0.00	\$ 35.02	0.0008	\$ 0.00	\$ 33.95	0.0008	\$ 0.00	\$ 39.19	0.0008	\$ 0.00
PLM/CHIP/TANF <1	\$ 28.22	3.4910	\$ 8.19	\$ 28.22	3.4826	\$ 8.17	\$ 32.21	3.4826	\$ 9.33	\$ 37.22	4.1651	\$ 12.89
PLM/CHIP/TANF 1 - 5	\$ 25.83	2.7831	\$ 5.64	\$ 25.83	2.7592	\$ 5.59	\$ 28.47	2.7592	\$ 6.18	\$ 33.48	3.3076	\$ 8.60
PLM/CHIP/TANF 6 - 18	\$ 50.64	3.3657	\$ 11.09	\$ 50.67	3.3381	\$ 11.00	\$ 55.46	3.3381	\$ 12.22	\$ 64.37	4.0051	\$ 16.99
OAA without Medicare	\$ 42.53	38.4131	\$ 113.06	\$ 42.66	37.6263	\$ 110.87	\$ 42.81	37.6263	\$ 111.94	\$ 49.41	42.2710	\$ 145.16
OAA with Medicare	\$ 39.79	75.5273	\$ 235.31	\$ 39.81	75.2384	\$ 234.48	\$ 38.57	75.2384	\$ 227.36	\$ 40.35	4.0185	\$ 13.11
OHP Adults & Couples	\$ 60.36	37.9814	\$ 169.58	\$ 60.36	37.9814	\$ 169.58	\$ 57.43	37.9814	\$ 161.38	\$ 63.83	42.1185	\$ 198.79
OHP Families	\$ 54.12	19.1704	\$ 77.84	\$ 54.12	19.1704	\$ 77.84	\$ 50.79	19.1704	\$ 72.81	\$ 56.48	22.1093	\$ 93.32
PLM Adults	\$ 32.91	8.5495	\$ 19.28	\$ 32.92	8.5404	\$ 19.27	\$ 35.08	8.5404	\$ 21.04	\$ 40.65	10.3755	\$ 29.57
SCF Children	\$ 70.71	8.6536	\$ 45.42	\$ 70.72	8.6211	\$ 45.25	\$ 80.73	8.6211	\$ 52.08	\$ 93.27	10.3289	\$ 72.08
TANF Adults	\$ 50.03	14.9558	\$ 51.03	\$ 50.15	14.7195	\$ 50.32	\$ 50.41	14.7195	\$ 50.99	\$ 58.36	17.9248	\$ 71.84
Prescription Drugs Total	\$ 58.94	21.8665	\$ 91.72	\$ 58.97	21.7154	\$ 91.09	\$ 58.40	21.7154	\$ 90.52	\$ 77.58	9.7396	\$ 55.19

<sup>1</sup>Unadjusted historical experience: July 2003 through June 2005 for OHP Plus and CY 2005 for OHP Standard, based on Exhibits 3, 4, and 5 of PricewaterhouseCoopers "Analysis of Calendar Years 2008 - 2009 Average Costs," dated September 22, 2006.

<sup>2</sup>Adjusted Historical Experience: Historical experience after the application of appropriate adjustments to the historical experience, e.g., claims completion factors and historical policy change adjustments. These adjustments are noted in the related category of service Appendix.

<sup>3</sup>Utilization per member (UPM): Units of service per member per year. UPM is calculated as total units divided by total member months, multiplied by 12.

<sup>4</sup>Per member per month (PMPM): Monthly reimbursement/cost per member per month. The PMPM value is calculated as reimbursement/cost per unit multiplied times UPM and divided by 12.

Unit type(s) for the Prescription Drugs category of service: Scripts or Claims.  
Sum of numbers may differ from totals due to rounding.

Managed Care Eligibility Group	Unadjusted Historical Experience <sup>1</sup>			Adjusted Historical Experience <sup>2</sup>			Historical Benchmark Rates			CY 2008-09 Benchmark Rates		
	Billed per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Billed per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>
AB/AD without Medicare	\$ 45.37	34.4723	\$ 130.34	\$ 45.37	34.4778	\$ 130.36	\$ 32.87	34.4778	\$ 94.45	\$ 38.24	41.4172	\$ 131.99
AB/AD with Medicare	\$ 42.50	45.9094	\$ 162.59	\$ 42.50	45.9623	\$ 162.77	\$ 30.24	45.9623	\$ 115.81	\$ 35.19	2.5574	\$ 7.50
CAWEM	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -
PLM/CHIP/TANF <1	\$ 25.64	3.9601	\$ 8.46	\$ 25.64	3.9446	\$ 8.43	\$ 20.84	3.9446	\$ 6.85	\$ 24.24	4.9699	\$ 10.04
PLM/CHIP/TANF 1 - 5	\$ 20.86	3.1258	\$ 5.43	\$ 20.86	3.0921	\$ 5.37	\$ 15.57	3.0921	\$ 4.01	\$ 18.11	3.8958	\$ 5.88
PLM/CHIP/TANF 6 - 18	\$ 33.31	2.9960	\$ 8.32	\$ 33.31	2.9663	\$ 8.23	\$ 24.49	2.9663	\$ 6.05	\$ 28.49	3.7373	\$ 8.87
OAA without Medicare	\$ 27.69	29.9238	\$ 69.06	\$ 27.69	29.8335	\$ 68.85	\$ 19.43	29.8335	\$ 48.32	\$ 22.61	35.8381	\$ 67.52
OAA with Medicare	\$ 29.97	56.9151	\$ 142.12	\$ 29.97	56.8636	\$ 141.99	\$ 20.82	56.8636	\$ 98.66	\$ 24.22	3.5187	\$ 7.10
OHP Adults & Couples	\$ 37.83	26.4727	\$ 83.46	\$ 37.83	26.4727	\$ 83.46	\$ 26.18	26.4727	\$ 57.76	\$ 29.15	30.2896	\$ 73.58
OHP Families	\$ 32.34	13.5850	\$ 36.61	\$ 32.34	13.5850	\$ 36.61	\$ 22.43	13.5850	\$ 25.39	\$ 24.97	15.4779	\$ 32.21
PLM Adults	\$ 22.88	10.6580	\$ 20.33	\$ 22.88	10.6600	\$ 20.33	\$ 17.56	10.6600	\$ 15.60	\$ 20.43	12.6973	\$ 21.62
SCF Children	\$ 47.50	6.1015	\$ 24.15	\$ 47.49	6.0600	\$ 23.98	\$ 35.50	6.0600	\$ 17.93	\$ 41.30	7.6351	\$ 26.27
TANF Adults	\$ 27.99	12.8897	\$ 30.06	\$ 27.99	12.8652	\$ 30.01	\$ 20.38	12.8652	\$ 21.85	\$ 23.70	15.3240	\$ 30.27
Prescription Drugs Total	\$ 36.10	13.5211	\$ 40.67	\$ 36.11	13.5001	\$ 40.62	\$ 25.93	13.5001	\$ 29.17	\$ 30.68	10.4090	\$ 26.61

<sup>1</sup>Unadjusted historical experience: July 2003 through June 2005 for OHP Plus and CY 2005 for OHP Standard, based on Exhibits 3, 4, and 5 of PricewaterhouseCoopers "Analysis of Calendar Years 2008 - 2009 Average Costs," dated September 22, 2006.

<sup>2</sup>Adjusted Historical Experience: Historical experience after the application of appropriate adjustments to the historical experience, e.g., claims completion factors and historical policy change adjustments. These adjustments are noted in the related category of service Appendix.

<sup>3</sup>Utilization per member (UPM): Units of service per member per year. UPM is calculated as total units divided by total member months, multiplied by 12.

<sup>4</sup>Per member per month (PMPM): Monthly billed/cost per member per month. The PMPM value is calculated as billed/cost per unit multiplied times UPM and divided by 12.

Unit type(s) for the Prescription Drugs category of service: Scripts or Claims.  
Sum of numbers may differ from totals due to rounding.

## Appendix D

## Mental Health Inpatient Benchmark Rate Development

### Approach: Provider Cost Data

Mercer’s approach involved a review of hospital-specific CCRs. The CCRs reflected a valuation of hospitals’ cost relative to their billed charge for a historical period.

### Additional Data Sets

- Medicaid cost report CCRs by facility, as provided by the DHS Actuarial Services Unit; and
- Inpatient mental health claims for OHP Plus (July 1, 2003 through June 30, 2005) and OHP Standard (CY 2005), by facility.

### Data Adjustments

Description of Adjustment Factor	Adjustment Factor
<b>Unit cost trend factor:</b> Annualized factor to trend benchmark cost per unit to projected study period of CY 2008–2009	+ 4.7%

#### Notes:

1. Annualized utilization trend factors to trend utilization per member to the projected study period of CY 2008–2009 were taken directly from the PWC September 22, 2006, *Analysis of Calendar Years 2008–2009 Average Costs*.
2. CCRs were used to derive benchmarks. It should be noted that the data time periods used in developing the CCRs for individual hospitals reflect a different period than included in the base data. In most cases, the data for specific hospitals to derive CCRs was found to overlap with the time period of the benchmarking base data. However, for the purpose of this report, no adjustment was made to factor in these timing differences.
3. Dual population (AB/AD with Medicare and OAA with Medicare) data was adjusted to reflect the outcome of the non-dual population categories. Dual population experience represented approximately 33 percent of the billed charges but only 4 percent of total payment. This is the result of Medicare being the primary payer for these services for the dual population. This adjustment was made to prevent Medicare charge data from having an unwarranted impact on benchmark calculations.

4. An adjustment was made to account for hospital supplemental payments. (see Appendix A: Hospital Benchmark Rate Development).
5. For information regarding data limitations, please refer to Mercer’s *SFY 2006–2007 Benchmark Rate Study—Oregon Health Plan: Technical Report, November 29, 2004*.

Mental Health Inpatient

Fee-for-Service Eligibility Category	Unadjusted Historical Experience <sup>1</sup>			Adjusted Historical Experience <sup>2</sup>			Historical Benchmark Rates			CY 2008-09 Benchmark Rates		
	Reimbursement per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Reimbursement per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>
AB/AD without Medicare	\$ 664.17	3.0183	\$ 167.06	\$ 664.17	3.0364	\$ 168.06	\$ 1,329.01	3.0364	\$ 336.28	\$ 1,661.13	3.5659	\$ 493.62
AB/AD with Medicare	\$ 40.19	2.4333	\$ 8.15	\$ 40.19	2.4844	\$ 8.32	\$ 49.27	2.4844	\$ 10.20	\$ 61.58	2.2856	\$ 11.73
CAWEM	\$ 828.97	0.0073	\$ 0.50	\$ 828.99	0.0073	\$ 0.51	\$ 1,977.97	0.0073	\$ 1.21	\$ 2,472.26	0.0073	\$ 1.51
PLM/CHIP/TANF <1	\$ 1,123.79	0.0192	\$ 1.79	\$ 1,123.80	0.0193	\$ 1.80	\$ 2,772.43	0.0193	\$ 4.45	\$ 3,465.26	0.0299	\$ 8.63
PLM/CHIP/TANF 1 - 5	\$ 320.15	0.0112	\$ 0.30	\$ 320.09	0.0113	\$ 0.30	\$ 586.08	0.0113	\$ 0.55	\$ 732.54	0.0175	\$ 1.07
PLM/CHIP/TANF 6 - 18	\$ 276.93	0.1718	\$ 3.96	\$ 276.92	0.1728	\$ 3.99	\$ 673.75	0.1728	\$ 9.70	\$ 842.12	0.2679	\$ 18.80
OAA without Medicare	\$ 837.88	0.8150	\$ 56.91	\$ 837.88	0.8199	\$ 57.25	\$ 1,616.27	0.8199	\$ 110.43	\$ 2,020.18	0.9629	\$ 162.10
OAA with Medicare	\$ 84.81	0.5200	\$ 3.67	\$ 84.81	0.5309	\$ 3.75	\$ 86.00	0.5309	\$ 3.80	\$ 107.49	0.4884	\$ 4.37
OHP Adults & Couples	\$ 969.28	1.4279	\$ 115.34	\$ 969.28	1.4350	\$ 115.91	\$ 1,508.20	1.4350	\$ 180.36	\$ 1,796.87	1.6470	\$ 246.62
OHP Families	\$ 761.02	0.4167	\$ 26.43	\$ 761.02	0.4188	\$ 26.56	\$ 1,202.41	0.4188	\$ 41.97	\$ 1,432.55	0.4926	\$ 58.80
PLM Adults	\$ 470.13	0.1294	\$ 5.07	\$ 470.13	0.1302	\$ 5.10	\$ 808.62	0.1302	\$ 8.77	\$ 1,010.69	0.1606	\$ 13.52
SCF Children	\$ 206.33	0.8264	\$ 14.21	\$ 206.33	0.8314	\$ 14.29	\$ 582.27	0.8314	\$ 40.34	\$ 727.77	1.2888	\$ 78.16
TANF Adults	\$ 931.07	0.4032	\$ 31.29	\$ 931.07	0.4056	\$ 31.47	\$ 1,578.17	0.4056	\$ 53.35	\$ 1,972.55	0.5002	\$ 82.22
Mental Health - Inpatient To	\$ 437.53	0.4063	\$ 14.82	\$ 435.87	0.4105	\$ 14.91	\$ 847.80	0.4105	\$ 29.00	\$ 1,103.00	0.4815	\$ 44.25

<sup>1</sup>Unadjusted historical experience: July 2003 through June 2005 for OHP Plus and CY 2005 for OHP Standard, based on Exhibits 3, 4, and 5 of PricewaterhouseCoopers "Analysis of Calendar Years 2008 - 2009 Average Costs," dated September 22, 2006.

<sup>2</sup>Adjusted Historical Experience: Historical experience after the application of appropriate adjustments to the historical experience, e.g., claims completion factors and historical policy change adjustments. These adjustments are noted in the related category of service Appendix.

<sup>3</sup>Utilization per member (UPM): Units of service per member per year. UPM is calculated as total units divided by total member months, multiplied by 12.

<sup>4</sup>Per member per month (PMPM): Monthly reimbursement/cost per member per month. The PMPM value is calculated as reimbursement/cost per unit multiplied times UPM and divided by 12.

Unit type(s) for the Mental Health - Inpatient category of service: Days or Services.  
Sum of numbers may differ from totals due to rounding.

Managed Care Eligibility Group	Unadjusted Historical Experience <sup>1</sup>			Adjusted Historical Experience <sup>2</sup>			Historical Benchmark Rates			CY 2008-09 Benchmark Rates		
	Billed per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Billed per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>
AB/AD without Medicare	\$ 461.49	1.1853	\$ 45.59	\$ 461.49	1.1925	\$ 45.86	\$ 272.28	1.1925	\$ 27.06	\$ 341.03	1.1925	\$ 33.89
AB/AD with Medicare	\$ 442.16	1.2908	\$ 47.56	\$ 49.81	1.3076	\$ 5.43	\$ 30.08	1.3076	\$ 3.28	\$ 37.68	1.4936	\$ 4.69
CAWEM	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -
PLM/CHIP/TANF <1	\$ 114.97	0.0005	\$ 0.00	\$ 113.78	0.0005	\$ 0.00	\$ 113.78	0.0005	\$ 0.00	\$ 142.51	0.0006	\$ 0.01
PLM/CHIP/TANF 1 - 5	\$ 111.04	0.0157	\$ 0.15	\$ 111.02	0.0158	\$ 0.15	\$ 76.71	0.0158	\$ 0.10	\$ 96.08	0.0201	\$ 0.16
PLM/CHIP/TANF 6 - 18	\$ 372.37	0.1411	\$ 4.38	\$ 372.37	0.1420	\$ 4.40	\$ 210.39	0.1420	\$ 2.49	\$ 263.51	0.1814	\$ 3.98
OAA without Medicare	\$ 735.78	0.1437	\$ 8.81	\$ 735.78	0.1446	\$ 8.86	\$ 448.82	0.1446	\$ 5.41	\$ 562.15	0.1446	\$ 6.77
OAA with Medicare	\$ 509.30	0.1756	\$ 7.45	\$ 45.25	0.1779	\$ 0.67	\$ 27.83	0.1779	\$ 0.41	\$ 34.85	0.2032	\$ 0.59
OHP Adults & Couples	\$ 504.98	0.4090	\$ 17.21	\$ 504.98	0.4110	\$ 17.30	\$ 308.54	0.4110	\$ 10.57	\$ 368.12	0.4110	\$ 12.61
OHP Families	\$ 562.74	0.1478	\$ 6.93	\$ 562.73	0.1485	\$ 6.97	\$ 324.14	0.1485	\$ 4.01	\$ 386.73	0.1647	\$ 5.31
PLM Adults	\$ 599.93	0.0525	\$ 2.63	\$ 599.93	0.0528	\$ 2.64	\$ 364.16	0.0528	\$ 1.60	\$ 456.11	0.0604	\$ 2.29
SCF Children	\$ 239.06	0.8975	\$ 17.88	\$ 239.06	0.9029	\$ 17.99	\$ 134.11	0.9029	\$ 10.09	\$ 167.98	1.1538	\$ 16.15
TANF Adults	\$ 383.02	0.2055	\$ 6.56	\$ 383.02	0.2068	\$ 6.60	\$ 230.19	0.2068	\$ 3.97	\$ 288.32	0.2362	\$ 5.67
Mental Health - Inpatient To	\$ 418.82	0.3441	\$ 12.01	\$ 303.89	0.3468	\$ 8.78	\$ 178.48	0.3468	\$ 5.16	\$ 216.26	0.3871	\$ 6.98

<sup>1</sup>Unadjusted historical experience: July 2003 through June 2005 for OHP Plus and CY 2005 for OHP Standard, based on Exhibits 3, 4, and 5 of PricewaterhouseCoopers "Analysis of Calendar Years 2008 - 2009 Average Costs," dated September 22, 2006.

<sup>2</sup>Adjusted Historical Experience: Historical experience after the application of appropriate adjustments to the historical experience, e.g., claims completion factors and historical policy change adjustments. These adjustments are noted in the related category of service Appendix.

<sup>3</sup>Utilization per member (UPM): Units of service per member per year. UPM is calculated as total units divided by total member months, multiplied by 12.

<sup>4</sup>Per member per month (PMPM): Monthly billed/cost per member per month. The PMPM value is calculated as billed/cost per unit multiplied times UPM and divided by 12.

Unit type(s) for the Mental Health - Inpatient category of service: Days or Services.  
Sum of numbers may differ from totals due to rounding.



Appendix E

## Mental Health Outpatient Benchmark Rate Development

### Approach: Cost-Adjusted Detailed Claims Data

Mercer’s approach involved a review of procedure-level Medicaid fee schedule conversions from 2003 to 2005. Detailed data constructed from an earlier period was used in the evaluation since updated provider cost information and procedure-level claim information was unavailable from the base period.

To evaluate changes in the base period, information was compiled and reviewed based on a crosswalk of prior procedure codes to new HIPAA compliant codes. Underlying changes in payment were measured (See Note 1). These measurements were combined with underlying cost changes to produce the benchmark conversion factors to convert payment to cost.

#### Additional Data Sets

Procedural-level data provided by the DHS Actuarial Services Unit for:

- OHP Standard (Incurred January 1, 2005–December 31, 2005); and
- OHP Plus (Incurred July 1, 2003–June 30, 2005).

#### Data Adjustments

Description of Adjustment Factor	Adjustment Factor
<b>Unit cost trend factor:</b> Annualized factor to trend benchmark cost per unit to projected study period of CY 2008–2009 (annualized)	+ 3.6%

#### Notes:

1. Annualized utilization trend factors to trend utilization per member to the projected study period of CY 2008–2009 were taken directly from the PWC September 22, 2006, *Analysis of Calendar Years 2008–2009 Average Costs*.
2. Oregon updated the Medicaid fee schedule multiple times during the two-year period of the base data. This included moving from “BA codes” to HIPAA compliant HCPCS/CPT codes. This conversion also changed many codes from a unit fee based on a time measurement of 15 minutes, to a unit fee based on

an hour of time. This is a contributing factor in the analysis. In addition, changes to assessment codes were shown to have a significant impact on expenditure increases for the FFS program.

Mental Health Outpatient

Fee-for-Service Eligibility Category	Unadjusted Historical Experience <sup>1</sup>			Adjusted Historical Experience <sup>2</sup>			Historical Benchmark Rates			CY 2008-09 Benchmark Rates		
	Reimbursement per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Reimbursement per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>
AB/AD without Medicare	\$ 88.82	9.8611	\$ 72.99	\$ 88.82	9.9202	\$ 73.42	\$ 93.35	9.9202	\$ 77.17	\$ 106.75	11.6554	\$ 103.68
AB/AD with Medicare	\$ 60.04	11.6366	\$ 58.23	\$ 60.04	11.8810	\$ 59.45	\$ 63.11	11.8810	\$ 62.48	\$ 72.16	10.9318	\$ 65.73
CAWEM	\$ 119.35	0.0001	\$ 0.00	\$ 121.48	0.0001	\$ 0.00	\$ 127.68	0.0001	\$ 0.00	\$ 145.98	0.0001	\$ 0.00
PLM/CHIP/TANF <1	\$ 98.87	0.0005	\$ 0.00	\$ 100.00	0.0005	\$ 0.00	\$ 105.10	0.0005	\$ 0.00	\$ 120.17	0.0008	\$ 0.01
PLM/CHIP/TANF 1 - 5	\$ 121.78	0.4745	\$ 4.82	\$ 121.79	0.4774	\$ 4.84	\$ 128.00	0.4774	\$ 5.09	\$ 146.37	0.7405	\$ 9.03
PLM/CHIP/TANF 6 - 18	\$ 132.81	2.0089	\$ 22.23	\$ 132.81	2.0209	\$ 22.37	\$ 139.58	2.0209	\$ 23.51	\$ 159.61	3.1351	\$ 41.70
OAA without Medicare	\$ 87.60	0.3855	\$ 2.81	\$ 87.60	0.3878	\$ 2.83	\$ 92.07	0.3878	\$ 2.98	\$ 105.26	0.4555	\$ 4.00
OAA with Medicare	\$ 91.42	0.2724	\$ 2.08	\$ 91.42	0.2782	\$ 2.12	\$ 96.08	0.2782	\$ 2.23	\$ 109.85	0.2560	\$ 2.34
OHP Adults & Couples	\$ 68.81	2.2683	\$ 13.01	\$ 68.81	2.2796	\$ 13.07	\$ 72.32	2.2796	\$ 13.74	\$ 80.33	2.6171	\$ 17.52
OHP Families	\$ 71.32	0.7385	\$ 4.39	\$ 71.32	0.7422	\$ 4.41	\$ 74.95	0.7422	\$ 4.64	\$ 83.26	0.8730	\$ 6.06
PLM Adults	\$ 69.40	0.1871	\$ 1.08	\$ 69.40	0.1882	\$ 1.09	\$ 72.94	0.1882	\$ 1.14	\$ 83.40	0.2321	\$ 1.61
SCF Children	\$ 143.14	10.5662	\$ 126.03	\$ 143.14	10.6296	\$ 126.79	\$ 150.44	10.6296	\$ 133.26	\$ 172.01	16.4887	\$ 236.35
TANF Adults	\$ 74.76	0.6608	\$ 4.12	\$ 74.77	0.6648	\$ 4.14	\$ 78.58	0.6648	\$ 4.35	\$ 89.84	0.8199	\$ 6.14
Mental Health - Outpatient	\$ 107.92	1.9395	\$ 17.44	\$ 107.80	1.9564	\$ 17.58	\$ 113.30	1.9564	\$ 18.47	\$ 136.55	2.5809	\$ 29.37

<sup>1</sup>Unadjusted historical experience: July 2003 through June 2005 for OHP Plus and CY 2005 for OHP Standard, based on Exhibits 3, 4, and 5 of PricewaterhouseCoopers "Analysis of Calendar Years 2008 - 2009 Average Costs," dated September 22, 2006.

<sup>2</sup>Adjusted Historical Experience: Historical experience after the application of appropriate adjustments to the historical experience, e.g., claims completion factors and historical policy change adjustments. These adjustments are noted in the related category of service Appendix.

<sup>3</sup>Utilization per member (UPM): Units of service per member per year. UPM is calculated as total units divided by total member months, multiplied by 12.

<sup>4</sup>Per member per month (PMPM): Monthly reimbursement/cost per member per month. The PMPM value is calculated as reimbursement/cost per unit multiplied times UPM and divided by 12.

Unit type(s) for the Mental Health - Outpatient category of service: Services or Claims.  
Sum of numbers may differ from totals due to rounding.

Managed Care Eligibility Group	Unadjusted Historical Experience <sup>1</sup>			Adjusted Historical Experience <sup>2</sup>			Historical Benchmark Rates			CY 2008-09 Benchmark Rates		
	Billed per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Billed per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>
AB/AD without Medicare	\$ 84.13	8.4914	\$ 59.53	\$ 84.13	8.5423	\$ 59.89	\$ 72.82	8.5423	\$ 51.84	\$ 83.32	8.6311	\$ 59.93
AB/AD with Medicare	\$ 76.81	10.2874	\$ 65.85	\$ 71.97	10.4212	\$ 62.50	\$ 62.29	10.4212	\$ 54.10	\$ 71.34	12.0284	\$ 71.51
CAWEM	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -
PLM/CHIP/TANF <1	\$ 124.13	0.0089	\$ 0.09	\$ 124.36	0.0089	\$ 0.09	\$ 107.65	0.0089	\$ 0.08	\$ 123.14	0.0115	\$ 0.12
PLM/CHIP/TANF 1 - 5	\$ 87.10	0.3187	\$ 2.31	\$ 87.10	0.3206	\$ 2.33	\$ 75.39	0.3206	\$ 2.01	\$ 86.29	0.4119	\$ 2.96
PLM/CHIP/TANF 6 - 18	\$ 99.89	1.2963	\$ 10.79	\$ 99.89	1.3040	\$ 10.85	\$ 86.46	1.3040	\$ 9.40	\$ 98.91	1.6779	\$ 13.83
OAA without Medicare	\$ 94.24	1.3778	\$ 10.82	\$ 94.24	1.3861	\$ 10.89	\$ 81.58	1.3861	\$ 9.42	\$ 93.42	1.3947	\$ 10.86
OAA with Medicare	\$ 87.82	0.8958	\$ 6.56	\$ 80.65	0.9074	\$ 6.10	\$ 69.81	0.9074	\$ 5.28	\$ 79.97	1.0450	\$ 6.96
OHP Adults & Couples	\$ 86.93	2.6128	\$ 18.93	\$ 86.93	2.6259	\$ 19.02	\$ 75.25	2.6259	\$ 16.47	\$ 83.55	2.6455	\$ 18.42
OHP Families	\$ 101.88	0.9393	\$ 7.97	\$ 101.88	0.9440	\$ 8.01	\$ 88.19	0.9440	\$ 6.94	\$ 97.99	1.0508	\$ 8.58
PLM Adults	\$ 97.41	0.5177	\$ 4.20	\$ 97.41	0.5208	\$ 4.23	\$ 84.31	0.5208	\$ 3.66	\$ 96.52	0.5980	\$ 4.81
SCF Children	\$ 126.45	8.6150	\$ 90.78	\$ 126.45	8.6667	\$ 91.33	\$ 109.46	8.6667	\$ 79.05	\$ 125.11	11.1573	\$ 116.32
TANF Adults	\$ 91.16	1.6569	\$ 12.59	\$ 91.16	1.6669	\$ 12.66	\$ 78.91	1.6669	\$ 10.96	\$ 90.31	1.9151	\$ 14.41
Mental Health - Outpatient	\$ 90.81	2.7292	\$ 20.65	\$ 89.40	2.7507	\$ 20.49	\$ 77.39	2.7507	\$ 17.74	\$ 89.40	3.1343	\$ 23.35

<sup>1</sup>Unadjusted historical experience: July 2003 through June 2005 for OHP Plus and CY 2005 for OHP Standard, based on Exhibits 3, 4, and 5 of PricewaterhouseCoopers "Analysis of Calendar Years 2008 - 2009 Average Costs," dated September 22, 2006.

<sup>2</sup>Adjusted Historical Experience: Historical experience after the application of appropriate adjustments to the historical experience, e.g., claims completion factors and historical policy change adjustments. These adjustments are noted in the related category of service Appendix.

<sup>3</sup>Utilization per member (UPM): Units of service per member per year. UPM is calculated as total units divided by total member months, multiplied by 12.

<sup>4</sup>Per member per month (PMPM): Monthly billed/cost per member per month. The PMPM value is calculated as billed/cost per unit multiplied times UPM and divided by 12.

Unit type(s) for the Mental Health - Outpatient category of service: Services or Claims.  
Sum of numbers may differ from totals due to rounding.

## Appendix F

## Chemical Dependency Benchmark Rate Development

### Approach: Provider Cost Data

Mercer’s approach involved an analysis of underlying changes in payment and benchmark cost for the period. We also utilized the Provider Cost Data Approach results from our prior study. Prior cost information was updated to reflect changes in payment policy. We noted virtually no change in the underlying fee schedules for Chemical Dependency treatment services over the period of time in the review.

Factored into the analysis was an underlying cost change for Chemical Dependency services for the period July 1, 2003 through June 30, 2005. A 3.0 percent annual factor was used for this purpose.

Although the developed benchmark costs are intended to be an approximation of the cost of services, more extensive analysis would be required to incorporate costs based on provider submitted cost data information.

#### Data Adjustments

Description of Adjustment Factor	Adjustment Factor
<b>Unit cost trend factor:</b> Annualized factor to trend benchmark cost per unit to projected study period of CY 2008–2009 (annualized)	+ 3.6%

#### Notes:

1. Annualized utilization trend factors to trend utilization per member to the projected study period of CY 2008–2009 were taken directly from the PWC September 22, 2006, *Analysis of Calendar Years 2008–2009 Average Costs*.
2. For information regarding data limitations, please refer to Mercer’s *SFY 2006–2007 Benchmark Rate Study—Oregon Health Plan: Technical Report, November 29, 2004*.

Chemical Dependency

Fee-for-Service Eligibility Category	Unadjusted Historical Experience <sup>1</sup>			Adjusted Historical Experience <sup>2</sup>			Historical Benchmark Rates			CY 2008-09 Benchmark Rates		
	Reimbursement per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Reimbursement per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>
AB/AD without Medicare	\$ 24.78	2.5888	\$ 5.35	\$ 24.78	2.6303	\$ 5.43	\$ 38.45	2.6303	\$ 8.43	\$ 43.97	3.0890	\$ 11.32
AB/AD with Medicare	\$ 26.71	1.7927	\$ 3.99	\$ 26.71	1.8017	\$ 4.01	\$ 41.46	1.8017	\$ 6.22	\$ 47.40	1.6576	\$ 6.55
CAWEM	\$ -	0.0000	\$ 0.00	\$ -	0.0000	\$ 0.00	\$ -	0.0000	\$ 0.00	\$ -	0.0000	\$ -
PLM/CHIP/TANF <1	\$ 37.70	0.0007	\$ 0.00	\$ 37.74	0.0007	\$ 0.00	\$ 58.57	0.0007	\$ 0.00	\$ 66.97	0.0012	\$ 0.01
PLM/CHIP/TANF 1 - 5	\$ 50.80	0.0027	\$ 0.01	\$ 50.91	0.0027	\$ 0.01	\$ 79.01	0.0027	\$ 0.02	\$ 90.34	0.0042	\$ 0.03
PLM/CHIP/TANF 6 - 18	\$ 50.88	0.3322	\$ 1.41	\$ 50.88	0.3376	\$ 1.43	\$ 78.96	0.3376	\$ 2.22	\$ 90.29	0.5233	\$ 3.94
OAA without Medicare	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -
OAA with Medicare	\$ 29.07	0.0363	\$ 0.09	\$ 29.06	0.0365	\$ 0.09	\$ 45.10	0.0365	\$ 0.14	\$ 51.57	0.0336	\$ 0.14
OHP Adults & Couples	\$ 30.24	5.5990	\$ 14.11	\$ 30.24	5.6549	\$ 14.25	\$ 46.93	5.6549	\$ 22.12	\$ 52.14	6.4904	\$ 28.20
OHP Families	\$ 32.57	1.5972	\$ 4.34	\$ 32.58	1.6132	\$ 4.38	\$ 50.56	1.6132	\$ 6.80	\$ 56.16	1.8972	\$ 8.88
PLM Adults	\$ 47.61	1.1768	\$ 4.67	\$ 47.61	1.1957	\$ 4.74	\$ 73.89	1.1957	\$ 7.36	\$ 84.49	1.4744	\$ 10.38
SCF Children	\$ 52.14	2.9964	\$ 13.02	\$ 52.14	3.0443	\$ 13.23	\$ 80.91	3.0443	\$ 20.53	\$ 92.52	4.7193	\$ 36.38
TANF Adults	\$ 40.48	3.2089	\$ 10.82	\$ 40.48	3.2602	\$ 11.00	\$ 62.82	3.2602	\$ 17.07	\$ 71.83	4.0202	\$ 24.06
<b>Chemical Dependency Total</b>	<b>\$ 36.51</b>	<b>0.9990</b>	<b>\$ 3.04</b>	<b>\$ 36.53</b>	<b>1.0126</b>	<b>\$ 3.08</b>	<b>\$ 56.69</b>	<b>1.0126</b>	<b>\$ 4.78</b>	<b>\$ 67.20</b>	<b>1.2546</b>	<b>\$ 7.03</b>

<sup>1</sup>Unadjusted historical experience: July 2003 through June 2005 for OHP Plus and CY 2005 for OHP Standard, based on Exhibits 3, 4, and 5 of PricewaterhouseCoopers "Analysis of Calendar Years 2008 - 2009 Average Costs," dated September 22, 2006.

<sup>2</sup>Adjusted Historical Experience: Historical experience after the application of appropriate adjustments to the historical experience, e.g., claims completion factors and historical policy change adjustments. These adjustments are noted in the related category of service Appendix.

<sup>3</sup>Utilization per member (UPM): Units of service per member per year. UPM is calculated as total units divided by total member months, multiplied by 12.

<sup>4</sup>Per member per month (PMPM): Monthly reimbursement/cost per member per month. The PMPM value is calculated as reimbursement/cost per unit multiplied times UPM and divided by 12.

Unit type(s) for the Chemical Dependency category of service: Services.  
Sum of numbers may differ from totals due to rounding.

Managed Care Eligibility Group	Unadjusted Historical Experience <sup>1</sup>			Adjusted Historical Experience <sup>2</sup>			Historical Benchmark Rates			CY 2008-09 Benchmark Rates		
	Billed per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Billed per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>
AB/AD without Medicare	\$ 38.84	2.1801	\$ 7.06	\$ 38.84	2.1932	\$ 7.10	\$ 26.65	2.1932	\$ 4.87	\$ 30.57	2.1932	\$ 5.59
AB/AD with Medicare	\$ 43.60	1.2589	\$ 4.57	\$ 34.57	1.2753	\$ 3.67	\$ 23.72	1.2753	\$ 2.52	\$ 27.21	1.4567	\$ 3.30
CAWEM	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -
PLM/CHIP/TANF <1	\$ 42.68	0.0011	\$ 0.00	\$ 43.25	0.0011	\$ 0.00	\$ 29.68	0.0011	\$ 0.00	\$ 34.05	0.0014	\$ 0.00
PLM/CHIP/TANF 1 - 5	\$ 62.90	0.0002	\$ 0.00	\$ 60.76	0.0002	\$ 0.00	\$ 41.69	0.0002	\$ 0.00	\$ 47.83	0.0003	\$ 0.00
PLM/CHIP/TANF 6 - 18	\$ 57.60	0.1525	\$ 0.73	\$ 57.60	0.1534	\$ 0.74	\$ 39.52	0.1534	\$ 0.51	\$ 45.34	0.1960	\$ 0.74
OAA without Medicare	\$ 171.21	0.0024	\$ 0.03	\$ 171.33	0.0024	\$ 0.03	\$ 117.56	0.0024	\$ 0.02	\$ 134.88	0.0024	\$ 0.03
OAA with Medicare	\$ 45.74	0.0916	\$ 0.35	\$ 39.52	0.0928	\$ 0.31	\$ 27.12	0.0928	\$ 0.21	\$ 31.11	0.1060	\$ 0.27
OHP Adults & Couples	\$ 37.83	5.4130	\$ 17.06	\$ 37.83	5.5213	\$ 17.40	\$ 25.96	5.5213	\$ 11.94	\$ 28.89	5.5213	\$ 13.29
OHP Families	\$ 38.71	0.8732	\$ 2.82	\$ 38.71	0.8906	\$ 2.87	\$ 26.56	0.8906	\$ 1.97	\$ 29.57	0.9877	\$ 2.43
PLM Adults	\$ 49.64	1.0190	\$ 4.21	\$ 49.64	1.0251	\$ 4.24	\$ 34.06	1.0251	\$ 2.91	\$ 39.07	1.1709	\$ 3.81
SCF Children	\$ 58.71	0.7910	\$ 3.87	\$ 58.71	0.7957	\$ 3.89	\$ 40.28	0.7957	\$ 2.67	\$ 46.21	1.0168	\$ 3.92
TANF Adults	\$ 46.37	2.1430	\$ 8.28	\$ 46.37	2.1558	\$ 8.33	\$ 31.82	2.1558	\$ 5.72	\$ 36.50	2.4625	\$ 7.49
<b>Chemical Dependency Total</b>	<b>\$ 43.48</b>	<b>0.8318</b>	<b>\$ 3.01</b>	<b>\$ 42.77</b>	<b>0.8398</b>	<b>\$ 2.99</b>	<b>\$ 29.34</b>	<b>0.8398</b>	<b>\$ 2.05</b>	<b>\$ 33.83</b>	<b>0.9129</b>	<b>\$ 2.57</b>

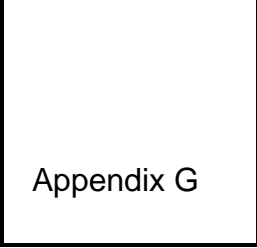
<sup>1</sup>Unadjusted historical experience: July 2003 through June 2005 for OHP Plus and CY 2005 for OHP Standard, based on Exhibits 3, 4, and 5 of PricewaterhouseCoopers "Analysis of Calendar Years 2008 - 2009 Average Costs," dated September 22, 2006.

<sup>2</sup>Adjusted Historical Experience: Historical experience after the application of appropriate adjustments to the historical experience, e.g., claims completion factors and historical policy change adjustments. These adjustments are noted in the related category of service Appendix.

<sup>3</sup>Utilization per member (UPM): Units of service per member per year. UPM is calculated as total units divided by total member months, multiplied by 12.

<sup>4</sup>Per member per month (PMPM): Monthly billed/cost per member per month. The PMPM value is calculated as billed/cost per unit multiplied times UPM and divided by 12.

Unit type(s) for the Chemical Dependency category of service: Services.  
Sum of numbers may differ from totals due to rounding.



Appendix G

## DME & Supplies Benchmark Rate Development

### Approach: Alternative Fee Schedule

Mercer's approach in determining the cost benchmark for DME/Supply services involved using an Alternative Fee Schedule Approach. The review was based on using Medicare and Medicaid DME/Supply fee schedule information.

The Medicare fee schedule for Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) was used to assist in cost benchmark development. Medicare perspectives on pricing DMEPOS services are provided in related documents referenced below. This includes perspectives on historical fee schedules, competitive pricing demonstrations, and related expansion efforts.

Pricing evaluations using Oregon Medicaid and Medicare DMEPOS fee schedule comparisons were used to derive cost benchmark rates. Oregon Medicaid codes were mapped to standard HCPCS procedure code information directly prior to this study period. Medicaid coverage is typically broader than Medicare coverage for these services, and data was reviewed to determine the proportion of Medicaid data matching to Medicare priced codes. The majority of dollars for DME/Supply services were positively identified.

As part of this review process, Mercer used several assumptions to approximate the cost benchmark data using Medicare fee relationships to the FFS Billed/Paid amount. Mercer's analysis includes the unit cost relationship of Medicaid and Medicare based on the FFS utilization. Please refer to Mercer's *SFY 2006–07 Benchmark Rate Study—Oregon Health Plan: Technical Report, November 29, 2004*, for additional information regarding this approach.

## Additional Data Sets

- Oregon Medicaid FFS DME & Supplies data for the period July 1, 2003 through June 30, 2005 (OHP Plus), and CY 2005 (OHP Standard);
- Oregon 2005 Medicaid fee schedule; and
- Medicare DMEPOS 2005 fee schedule for the State of Oregon.

## Data Adjustments

Description of Adjustment Factor	Adjustment Factor
<b>Unit cost trend factor:</b> Annualized factor to trend benchmark cost per unit to projected study period of CY 2008–2009 (annualized)	+ 2.8%

### Notes:

1. Annualized utilization trend factors to trend utilization per member to the projected study period of CY 2008–2009 were taken directly from PWC’s September 22, 2006, *Analysis of Calendar Years 2008–2009 Average Costs*.

DME & Supplies

Fee-for-Service Eligibility Category	Unadjusted Historical Experience <sup>1</sup>			Adjusted Historical Experience <sup>2</sup>			Historical Benchmark Rates			CY 2008-09 Benchmark Rates		
	Reimbursement per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Reimbursement per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>
AB/AD without Medicare	\$ 2.58	240.5814	\$ 51.66	\$ 2.58	243.9419	\$ 52.38	\$ 2.81	243.9419	\$ 57.05	\$ 3.17	287.4424	\$ 76.00
AB/AD with Medicare	\$ 1.32	219.0857	\$ 24.12	\$ 1.32	219.7407	\$ 24.19	\$ 1.43	219.7407	\$ 26.19	\$ 1.62	277.8272	\$ 37.44
CAWEM	\$ 6.57	0.0075	\$ 0.00	\$ 6.51	0.0076	\$ 0.00	\$ 7.08	0.0076	\$ 0.00	\$ 8.01	0.0076	\$ 0.01
PLM/CHIP/TANF <1	\$ 14.70	2.3805	\$ 2.92	\$ 14.70	2.4138	\$ 2.96	\$ 15.98	2.4138	\$ 3.22	\$ 18.07	2.9580	\$ 4.45
PLM/CHIP/TANF 1 - 5	\$ 5.22	1.5468	\$ 0.67	\$ 5.22	1.5590	\$ 0.68	\$ 5.66	1.5590	\$ 0.74	\$ 6.40	1.9105	\$ 1.02
PLM/CHIP/TANF 6 - 18	\$ 3.67	1.7809	\$ 0.54	\$ 3.67	1.7985	\$ 0.55	\$ 3.98	1.7985	\$ 0.60	\$ 4.50	2.2040	\$ 0.83
OAA without Medicare	\$ 2.11	127.2955	\$ 22.33	\$ 2.11	128.9442	\$ 22.62	\$ 2.30	128.9442	\$ 24.69	\$ 2.60	151.9380	\$ 32.89
OAA with Medicare	\$ 1.00	356.2325	\$ 29.70	\$ 1.00	357.6556	\$ 29.82	\$ 1.08	357.6556	\$ 32.18	\$ 1.22	452.1987	\$ 45.99
OHP Adults & Couples	\$ 10.41	6.7832	\$ 5.88	\$ 10.41	6.8510	\$ 5.94	\$ 11.30	6.8510	\$ 6.45	\$ 12.53	7.8857	\$ 8.23
OHP Families	\$ 29.39	1.5440	\$ 3.78	\$ 29.39	1.5595	\$ 3.82	\$ 31.85	1.5595	\$ 4.14	\$ 35.30	1.7977	\$ 5.29
PLM Adults	\$ 12.29	2.7259	\$ 2.79	\$ 12.29	2.7696	\$ 2.84	\$ 13.18	2.7696	\$ 3.04	\$ 14.90	3.2732	\$ 4.07
SCF Children	\$ 2.41	24.4427	\$ 4.91	\$ 2.41	24.7592	\$ 4.97	\$ 2.62	24.7592	\$ 5.41	\$ 2.97	30.3414	\$ 7.50
TANF Adults	\$ 11.14	2.8236	\$ 2.62	\$ 11.14	2.8573	\$ 2.65	\$ 12.14	2.8573	\$ 2.89	\$ 13.73	3.3769	\$ 3.86
DME/Supplies Total	\$ 1.56	85.6166	\$ 11.10	\$ 1.56	86.1680	\$ 11.20	\$ 1.69	86.1680	\$ 12.14	\$ 1.88	107.0127	\$ 16.80

<sup>1</sup>Unadjusted historical experience: July 2003 through June 2005 for OHP Plus and CY 2005 for OHP Standard, based on Exhibits 3, 4, and 5 of PricewaterhouseCoopers "Analysis of Calendar Years 2008 - 2009 Average Costs," dated September 22, 2006.

<sup>2</sup>Adjusted Historical Experience: Historical experience after the application of appropriate adjustments to the historical experience, e.g., claims completion factors and historical policy change adjustments. These adjustments are noted in the related category of service Appendix.

<sup>3</sup>Utilization per member (UPM): Units of service per member per year. UPM is calculated as total units divided by total member months, multiplied by 12.

<sup>4</sup>Per member per month (PMPM): Monthly reimbursement/cost per member per month. The PMPM value is calculated as reimbursement/cost per unit multiplied times UPM and divided by 12.

Unit type(s) for the DME/Supplies category of service: Services or CPT Code Units.

Sum of numbers may differ from totals due to rounding.

Managed Care Eligibility Group	Unadjusted Historical Experience <sup>1</sup>			Adjusted Historical Experience <sup>2</sup>			Historical Benchmark Rates			CY 2008-09 Benchmark Rates		
	Billed per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Billed per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>
AB/AD without Medicare	\$ 3.83	125.5726	\$ 40.07	\$ 3.83	125.8208	\$ 40.14	\$ 2.64	125.8208	\$ 27.63	\$ 3.01	154.4844	\$ 38.75
AB/AD with Medicare	\$ 3.35	158.1683	\$ 44.18	\$ 1.70	159.5835	\$ 22.64	\$ 1.23	159.5835	\$ 16.37	\$ 1.41	190.7361	\$ 22.36
CAWEM	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -
PLM/CHIP/TANF <1	\$ 26.01	1.6323	\$ 3.54	\$ 26.01	1.6355	\$ 3.55	\$ 18.18	1.6355	\$ 2.48	\$ 20.77	1.9775	\$ 3.42
PLM/CHIP/TANF 1 - 5	\$ 8.04	1.2731	\$ 0.85	\$ 8.04	1.2666	\$ 0.85	\$ 5.67	1.2666	\$ 0.60	\$ 6.47	1.5315	\$ 0.83
PLM/CHIP/TANF 6 - 18	\$ 10.32	0.7194	\$ 0.62	\$ 10.32	0.7165	\$ 0.62	\$ 7.22	0.7165	\$ 0.43	\$ 8.24	0.8663	\$ 0.60
OAA without Medicare	\$ 2.05	114.1581	\$ 19.48	\$ 2.05	114.1540	\$ 19.48	\$ 1.41	114.1540	\$ 13.43	\$ 1.61	140.1597	\$ 18.83
OAA with Medicare	\$ 2.75	237.6405	\$ 54.56	\$ 1.33	240.0077	\$ 26.53	\$ 0.96	240.0077	\$ 19.11	\$ 1.09	286.8600	\$ 26.09
OHP Adults & Couples	\$ 28.90	2.5626	\$ 6.17	\$ 28.91	2.5677	\$ 6.18	\$ 20.10	2.5677	\$ 4.30	\$ 22.31	3.0169	\$ 5.61
OHP Families	\$ 10.65	2.8550	\$ 2.53	\$ 10.65	2.8607	\$ 2.54	\$ 7.48	2.8607	\$ 1.78	\$ 8.30	3.2214	\$ 2.23
PLM Adults	\$ 20.31	1.3138	\$ 2.22	\$ 20.31	1.3217	\$ 2.24	\$ 14.53	1.3217	\$ 1.60	\$ 16.60	1.5232	\$ 2.11
SCF Children	\$ 4.04	11.5180	\$ 3.88	\$ 4.04	11.5060	\$ 3.87	\$ 2.85	11.5060	\$ 2.73	\$ 3.26	13.9119	\$ 3.78
TANF Adults	\$ 20.99	1.6011	\$ 2.80	\$ 20.99	1.6043	\$ 2.81	\$ 14.44	1.6043	\$ 1.93	\$ 16.50	1.8488	\$ 2.54
DME/Supplies Total	\$ 3.65	34.0998	\$ 10.37	\$ 2.77	34.3124	\$ 7.91	\$ 1.94	34.3124	\$ 5.54	\$ 2.22	41.4358	\$ 7.65

<sup>1</sup>Unadjusted historical experience: July 2003 through June 2005 for OHP Plus and CY 2005 for OHP Standard, based on Exhibits 3, 4, and 5 of PricewaterhouseCoopers "Analysis of Calendar Years 2008 - 2009 Average Costs," dated September 22, 2006.

<sup>2</sup>Adjusted Historical Experience: Historical experience after the application of appropriate adjustments to the historical experience, e.g., claims completion factors and historical policy change adjustments. These adjustments are noted in the related category of service Appendix.

<sup>3</sup>Utilization per member (UPM): Units of service per member per year. UPM is calculated as total units divided by total member months, multiplied by 12.

<sup>4</sup>Per member per month (PMPM): Monthly billed/cost per member per month. The PMPM value is calculated as billed/cost per unit multiplied times UPM and divided by 12.

Unit type(s) for the DME/Supplies category of service: Services or CPT Code Units.

Sum of numbers may differ from totals due to rounding.



## Appendix H

## Dental Benchmark Rate Development

### Approach: Cost-Adjusted Usual & Customary Commercial Charges

Mercer’s approach involved a review of procedural-level FFS utilization and reimbursement data and managed care billed charges data as compared to the 50th percentile of Usual & Customary charges. Please refer to Mercer’s *SFY 2006–2007 Benchmark Rate Study—Oregon Health Plan: Technical Report, November 29, 2004*, for additional information regarding this approach.

### Additional Data Sets

- Ingenix procedural-level Oregon dental data for the period October 1, 2005 through September 30, 2006, which contains the calculated 50th percentile of Usual & Customary charges for Indemnity and PPO claims. The data set contained over \$160 million in total submitted charges.

### Data Adjustments

Description of Adjustment Factor	Adjustment Factor
<b>Unit cost trend factor:</b> Annualized factor to trend benchmark cost per unit to projected study period of CY 2008–2009 (annualized)	+ 4.0%

#### Notes:

1. Annualized utilization trend factors to trend utilization per member to the projected study period of CY 2008–2009 were taken directly from PWC’s September 22, 2006, *Analysis of Calendar Years 2008–2009 Average Costs*.
2. Final cost benchmarks represent OHP’s share of cost, net of OHP Plus enrollee copayments, Medicare payments, and other TPL. Given that the Ingenix cost comparison data set was not adjusted to only include OHP’s share of cost, FFS reimbursement was increased by a factor of 3.19 percent to approximate total provider reimbursement, which allowed for the development of the FFS reimbursement-to-cost conversion factor.

3. The Ingenix dental data set has a data period mid-point of April 1, 2006. The Ingenix Usual & Customary fees were back-trended 21 months for the OHP Plus eligibility groups and 9 months for the OHP Standard eligibility groups, using a 4 percent cost trend factor.

Dental

Fee-for-Service Eligibility Category	Unadjusted Historical Experience <sup>1</sup>			Adjusted Historical Experience <sup>2</sup>			Historical Benchmark Rates			CY 2008-09 Benchmark Rates		
	Reimbursement per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Reimbursement per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>
AB/AD without Medicare	\$ 42.15	0.3555	\$ 1.25	\$ 42.15	0.3562	\$ 1.25	\$ 60.09	0.3562	\$ 1.78	\$ 72.58	0.4385	\$ 2.65
AB/AD with Medicare	\$ 46.54	0.2997	\$ 1.16	\$ 46.54	0.3006	\$ 1.17	\$ 72.31	0.3006	\$ 1.81	\$ 87.33	0.4329	\$ 3.15
CAWEM	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -
PLM/CHIP/TANF <1	\$ 32.78	0.0028	\$ 0.01	\$ 32.51	0.0028	\$ 0.01	\$ 37.71	0.0028	\$ 0.01	\$ 45.54	0.0038	\$ 0.01
PLM/CHIP/TANF 1 - 5	\$ 35.09	0.3489	\$ 1.02	\$ 35.08	0.3496	\$ 1.02	\$ 52.33	0.3496	\$ 1.52	\$ 63.19	0.4745	\$ 2.50
PLM/CHIP/TANF 6 - 18	\$ 30.34	0.4659	\$ 1.18	\$ 30.34	0.4668	\$ 1.18	\$ 43.95	0.4668	\$ 1.71	\$ 53.07	0.6335	\$ 2.80
OAA without Medicare	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -
OAA with Medicare	\$ 58.32	0.1165	\$ 0.57	\$ 58.33	0.1168	\$ 0.57	\$ 89.19	0.1168	\$ 0.87	\$ 107.71	0.1683	\$ 1.51
OHP Adults & Couples	\$ 42.61	0.1034	\$ 0.37	\$ 42.61	0.1036	\$ 0.37	\$ 52.70	0.1036	\$ 0.46	\$ 60.64	0.1203	\$ 0.61
OHP Families	\$ 36.78	0.0799	\$ 0.24	\$ 36.79	0.0800	\$ 0.25	\$ 49.61	0.0800	\$ 0.33	\$ 57.08	0.0910	\$ 0.43
PLM Adults	\$ 35.83	0.2028	\$ 0.61	\$ 35.84	0.2032	\$ 0.61	\$ 54.31	0.2032	\$ 0.92	\$ 65.58	0.2398	\$ 1.31
SCF Children	\$ 33.30	0.7954	\$ 2.21	\$ 33.30	0.7970	\$ 2.21	\$ 49.66	0.7970	\$ 3.30	\$ 59.97	1.0815	\$ 5.40
TANF Adults	\$ 41.78	0.3248	\$ 1.13	\$ 41.78	0.3254	\$ 1.13	\$ 61.86	0.3254	\$ 1.68	\$ 74.71	0.3839	\$ 2.39
Dental Total	\$ 35.56	0.2448	\$ 0.73	\$ 35.56	0.2453	\$ 0.73	\$ 52.35	0.2453	\$ 1.07	\$ 63.10	0.3256	\$ 1.71

<sup>1</sup>Unadjusted historical experience: July 2003 through June 2005 for OHP Plus and CY 2005 for OHP Standard, based on Exhibits 3, 4, and 5 of PricewaterhouseCoopers "Analysis of Calendar Years 2008 - 2009 Average Costs," dated September 22, 2006.

<sup>2</sup>Adjusted Historical Experience: Historical experience after the application of appropriate adjustments to the historical experience, e.g., claims completion factors and historical policy change adjustments. These adjustments are noted in the related category of service Appendix.

<sup>3</sup>Utilization per member (UPM): Units of service per member per year. UPM is calculated as total units divided by total member months, multiplied by 12.

<sup>4</sup>Per member per month (PMPM): Monthly reimbursement/cost per member per month. The PMPM value is calculated as reimbursement/cost per unit multiplied times UPM and divided by 12.

Unit type(s) for the Dental category of service: Services.  
Sum of numbers may differ from totals due to rounding.

Managed Care Eligibility Group	Unadjusted Historical Experience <sup>1</sup>			Adjusted Historical Experience <sup>2</sup>			Historical Benchmark Rates			CY 2008-09 Benchmark Rates		
	Billed per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Billed per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>
AB/AD without Medicare	\$ 80.65	3.2089	\$ 21.57	\$ 80.65	3.2475	\$ 21.83	\$ 63.03	3.2475	\$ 17.06	\$ 76.92	3.8796	\$ 24.87
AB/AD with Medicare	\$ 82.14	3.6891	\$ 25.25	\$ 82.14	3.7223	\$ 25.48	\$ 64.46	3.7223	\$ 20.00	\$ 78.67	4.3707	\$ 28.65
CAWEM	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -
PLM/CHIP/TANF <1	\$ 46.45	0.0344	\$ 0.13	\$ 46.41	0.0349	\$ 0.13	\$ 37.81	0.0349	\$ 0.11	\$ 46.14	0.0396	\$ 0.15
PLM/CHIP/TANF 1 - 5	\$ 63.25	2.6771	\$ 14.11	\$ 63.25	2.7092	\$ 14.28	\$ 45.74	2.7092	\$ 10.33	\$ 55.82	3.0766	\$ 14.31
PLM/CHIP/TANF 6 - 18	\$ 54.58	3.9681	\$ 18.05	\$ 54.58	4.0157	\$ 18.26	\$ 40.87	4.0157	\$ 13.68	\$ 49.88	4.5602	\$ 18.96
OAA without Medicare	\$ 102.04	2.9038	\$ 24.69	\$ 102.04	2.9387	\$ 24.99	\$ 82.24	2.9387	\$ 20.14	\$ 100.36	3.5107	\$ 29.36
OAA with Medicare	\$ 93.73	1.9278	\$ 15.06	\$ 93.73	1.9452	\$ 15.19	\$ 78.00	1.9452	\$ 12.64	\$ 95.19	2.2840	\$ 18.12
OHP Adults & Couples	\$ 61.73	0.8701	\$ 4.48	\$ 61.73	0.8718	\$ 4.48	\$ 43.60	0.8718	\$ 3.17	\$ 50.47	0.9972	\$ 4.19
OHP Families	\$ 60.66	0.7986	\$ 4.04	\$ 60.66	0.8002	\$ 4.05	\$ 43.45	0.8002	\$ 2.90	\$ 50.30	0.8924	\$ 3.74
PLM Adults	\$ 66.53	3.6774	\$ 20.39	\$ 66.53	3.7215	\$ 20.63	\$ 53.56	3.7215	\$ 16.61	\$ 65.36	4.2261	\$ 23.02
SCF Children	\$ 53.69	3.9725	\$ 17.77	\$ 53.69	4.0202	\$ 17.99	\$ 41.82	4.0202	\$ 14.01	\$ 51.03	4.5653	\$ 19.42
TANF Adults	\$ 80.08	3.9326	\$ 26.24	\$ 80.08	3.9798	\$ 26.56	\$ 61.09	3.9798	\$ 20.26	\$ 74.55	4.5195	\$ 28.08
Dental Total	\$ 67.00	3.1040	\$ 17.33	\$ 67.00	3.1397	\$ 17.53	\$ 51.17	3.1397	\$ 13.39	\$ 62.60	3.6014	\$ 18.79

<sup>1</sup>Unadjusted historical experience: July 2003 through June 2005 for OHP Plus and CY 2005 for OHP Standard, based on Exhibits 3, 4, and 5 of PricewaterhouseCoopers "Analysis of Calendar Years 2008 - 2009 Average Costs," dated September 22, 2006.

<sup>2</sup>Adjusted Historical Experience: Historical experience after the application of appropriate adjustments to the historical experience, e.g., claims completion factors and historical policy change adjustments. These adjustments are noted in the related category of service Appendix.

<sup>3</sup>Utilization per member (UPM): Units of service per member per year. UPM is calculated as total units divided by total member months, multiplied by 12.

<sup>4</sup>Per member per month (PMPM): Monthly billed/cost per member per month. The PMPM value is calculated as billed/cost per unit multiplied times UPM and divided by 12.

Unit type(s) for the Dental category of service: Services.  
Sum of numbers may differ from totals due to rounding.



Appendix I

## Other Services Benchmark Rate Development

### Approaches: Modified Medicaid Data and Alternative Fee Schedules

The remaining sub-categories were divided into Transportation, Home Health, Vision, and Not Elsewhere Classified groupings. The methodology used to develop benchmark rates varies by and even within groupings. Limited new detailed data was available and details from prior historical data were used to the extent necessary in benchmark development.

Medicaid and Medicare fee schedule payment rates were reviewed when applicable. Fee schedule comparisons were made when service coding and payment methods were similar and reasonably consistent. These included emergency transportation services, and some home health care and vision services. Accessibility to cost data for these categories was limited and several assumptions to best approximate historical unit cost benchmark were utilized. In circumstances when marketplace coverage is not usually available (i.e., non-emergent transportation), our experience working with other Medicaid programs enabled us to provide an estimate of reasonable unit cost benchmarks.

Professional Services COS benchmark factors were utilized for the Not Elsewhere Classified grouping. Case Management and School-Based Services represent the vast majority of the data in this grouping. These services are similar to many professional services that use a cognitive approach for their delivery to patients, and Professional Services COS benchmark factors were assumed to best represent the results for this grouping.

It should be noted that PWC reported home health care and private duty nursing services together as one subcategory of service. Additionally, some home health care utilization is also aggregated into the Hospital service category. Thus, reimbursement per unit, billed per unit and utilization per member (UPM) could not be developed separately for home health care. The DHS Actuarial Services Unit and PWC performed a study of home health agency costs in 2002 and estimated that the Medicaid FFS fee schedule was on

average at 38.7 percent of cost. Mercer did not receive sufficient data to replicate or validate the results of this study.

## Additional Data Sets

- Oregon Medicaid Fee Schedule; and
- Medicare Ambulance Fee Schedule.

### Data Adjustments

Description of Adjustment Factor	Adjustment Factor
<b>Unit cost trend factor:</b> Annualized factor to trend benchmark cost per unit to projected study period of CY 2008–2009 (annualized)	
Home Health Care	3.2%
Transportation	4.0%
Vision	2.7%
Not Elsewhere Classified	3.1%

#### Notes:

1. Annualized utilization trend factors to trend utilization per member to the projected study period of CY 2008–2009 were taken directly from PWC’s September 22, 2006, *Analysis of Calendar Years 2008–2009 Average Costs*.
2. Referenced materials:
  - <http://www.cms.hhs.gov/AmbulanceFeeSchedule/>
  - MedPac Databook: June 2004, Health Care Spending and the Medicare Program Section 9: Post Acute Care, Home Health Services
  - [http://www.medpac.gov/publications/congressional\\_reports/Mar04\\_Ch3D.pdf](http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3D.pdf)

Home Health

Fee-for-Service Eligibility Category	Unadjusted Historical Experience <sup>1</sup>			Adjusted Historical Experience <sup>2</sup>			Historical Benchmark Rates			CY 2008-09 Benchmark Rates		
	Reimbursement per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Reimbursement per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>
AB/AD without Medicare	\$ 167.94	0.4873	\$ 6.82	\$ 167.94	0.4941	\$ 6.91	\$ 209.92	0.4941	\$ 8.64	\$ 238.03	0.5822	\$ 11.55
AB/AD with Medicare	\$ 97.35	0.0857	\$ 0.70	\$ 97.36	0.0860	\$ 0.70	\$ 121.70	0.0860	\$ 0.87	\$ 138.00	0.1087	\$ 1.25
CAWEM	\$ 53.03	0.0001	\$ 0.00	\$ 55.26	0.0001	\$ 0.00	\$ 0.00	0.0001	\$ 0.00	\$ 0.00	0.0001	\$ 0.00
PLM/CHIP/TANF <1	\$ 142.60	0.0484	\$ 0.58	\$ 142.61	0.0491	\$ 0.58	\$ 178.26	0.0491	\$ 0.73	\$ 202.13	0.0602	\$ 1.01
PLM/CHIP/TANF 1 - 5	\$ 150.84	0.0177	\$ 0.22	\$ 150.84	0.0178	\$ 0.22	\$ 188.55	0.0178	\$ 0.28	\$ 213.80	0.0219	\$ 0.39
PLM/CHIP/TANF 6 - 18	\$ 99.67	0.0106	\$ 0.09	\$ 99.72	0.0108	\$ 0.09	\$ 124.65	0.0108	\$ 0.11	\$ 141.34	0.0132	\$ 0.16
OAA without Medicare	\$ 119.24	0.2894	\$ 2.88	\$ 119.24	0.2931	\$ 2.91	\$ 149.05	0.2931	\$ 3.64	\$ 169.01	0.3454	\$ 4.86
OAA with Medicare	\$ 101.19	0.1233	\$ 1.04	\$ 101.19	0.1238	\$ 1.04	\$ 126.49	0.1238	\$ 1.30	\$ 143.43	0.1565	\$ 1.87
OHP Adults & Couples	\$ 128.08	0.0077	\$ 0.08	\$ 128.05	0.0078	\$ 0.08	\$ 160.06	0.0078	\$ 0.10	\$ 176.66	0.0089	\$ 0.13
OHP Families	\$ 121.36	0.0017	\$ 0.02	\$ 121.28	0.0017	\$ 0.02	\$ 151.60	0.0017	\$ 0.02	\$ 167.32	0.0019	\$ 0.03
PLM Adults	\$ 156.89	0.0158	\$ 0.21	\$ 156.89	0.0161	\$ 0.21	\$ 196.11	0.0161	\$ 0.26	\$ 222.37	0.0190	\$ 0.35
SCF Children	\$ 183.58	0.0775	\$ 1.18	\$ 183.57	0.0785	\$ 1.20	\$ 229.46	0.0785	\$ 1.50	\$ 260.19	0.0962	\$ 2.08
TANF Adults	\$ 117.90	0.0329	\$ 0.32	\$ 117.89	0.0333	\$ 0.33	\$ 147.37	0.0333	\$ 0.41	\$ 167.10	0.0394	\$ 0.55
Home Health Total	\$ 144.42	0.0778	\$ 0.94	\$ 144.55	0.0786	\$ 0.95	\$ 180.68	0.0786	\$ 1.18	\$ 203.64	0.0951	\$ 1.61

<sup>1</sup>Unadjusted historical experience: July 2003 through June 2005 for OHP Plus and CY 2005 for OHP Standard, based on Exhibits 3, 4, and 5 of PricewaterhouseCoopers "Analysis of Calendar Years 2008 - 2009 Average Costs," dated September 22, 2006.

<sup>2</sup>Adjusted Historical Experience: Historical experience after the application of appropriate adjustments to the historical experience, e.g., claims completion factors and historical policy change adjustments. These adjustments are noted in the related category of service Appendix.

<sup>3</sup>Utilization per member (UPM): Units of service per member per year. UPM is calculated as total units divided by total member months, multiplied by 12.

<sup>4</sup>Per member per month (PMPM): Monthly reimbursement/cost per member per month. The PMPM value is calculated as reimbursement/cost per unit multiplied times UPM and divided by 12.

Unit type(s) for the Home Health category of service: Claims.  
Sum of numbers may differ from totals due to rounding.

Managed Care Eligibility Group	Unadjusted Historical Experience <sup>1</sup>			Adjusted Historical Experience <sup>2</sup>			Historical Benchmark Rates			CY 2008-09 Benchmark Rates		
	Billed per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Billed per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>
AB/AD without Medicare	\$ 458.46	0.2009	\$ 7.68	\$ 458.46	0.2013	\$ 7.69	\$ 298.00	0.2013	\$ 5.00	\$ 338.89	0.2472	\$ 6.98
AB/AD with Medicare	\$ 249.50	0.0716	\$ 1.49	\$ 0.00	0.0722	\$ 0.00	\$ 0.00	0.0722	\$ 0.00	\$ 0.00	0.0863	\$ 0.00
CAWEM	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -
PLM/CHIP/TANF <1	\$ 275.78	0.0286	\$ 0.66	\$ 275.78	0.0287	\$ 0.66	\$ 179.26	0.0287	\$ 0.43	\$ 203.85	0.0347	\$ 0.59
PLM/CHIP/TANF 1 - 5	\$ 305.71	0.0082	\$ 0.21	\$ 305.67	0.0081	\$ 0.21	\$ 198.68	0.0081	\$ 0.13	\$ 225.94	0.0099	\$ 0.19
PLM/CHIP/TANF 6 - 18	\$ 226.12	0.0054	\$ 0.10	\$ 226.12	0.0054	\$ 0.10	\$ 146.98	0.0054	\$ 0.07	\$ 167.14	0.0065	\$ 0.09
OAA without Medicare	\$ 378.19	0.1446	\$ 4.56	\$ 378.19	0.1446	\$ 4.56	\$ 245.83	0.1446	\$ 2.96	\$ 279.55	0.1776	\$ 4.14
OAA with Medicare	\$ 262.39	0.0613	\$ 1.34	\$ 0.00	0.0619	\$ 0.00	\$ 0.00	0.0619	\$ 0.00	\$ 0.00	0.0739	\$ 0.00
OHP Adults & Couples	\$ 270.56	0.0104	\$ 0.23	\$ 270.57	0.0104	\$ 0.23	\$ 175.87	0.0104	\$ 0.15	\$ 194.51	0.0122	\$ 0.20
OHP Families	\$ 260.52	0.0051	\$ 0.11	\$ 260.58	0.0051	\$ 0.11	\$ 169.38	0.0051	\$ 0.07	\$ 187.33	0.0057	\$ 0.09
PLM Adults	\$ 322.47	0.0230	\$ 0.62	\$ 322.46	0.0232	\$ 0.62	\$ 209.60	0.0232	\$ 0.40	\$ 238.36	0.0267	\$ 0.53
SCF Children	\$ 361.41	0.0258	\$ 0.78	\$ 361.41	0.0257	\$ 0.77	\$ 234.91	0.0257	\$ 0.50	\$ 267.14	0.0311	\$ 0.69
TANF Adults	\$ 275.55	0.0263	\$ 0.60	\$ 275.55	0.0264	\$ 0.61	\$ 179.11	0.0264	\$ 0.39	\$ 203.68	0.0304	\$ 0.52
Home Health Total	\$ 374.04	0.0376	\$ 1.17	\$ 328.96	0.0377	\$ 1.03	\$ 213.82	0.0377	\$ 0.67	\$ 244.58	0.0456	\$ 0.93

<sup>1</sup>Unadjusted historical experience: July 2003 through June 2005 for OHP Plus and CY 2005 for OHP Standard, based on Exhibits 3, 4, and 5 of PricewaterhouseCoopers "Analysis of Calendar Years 2008 - 2009 Average Costs," dated September 22, 2006.

<sup>2</sup>Adjusted Historical Experience: Historical experience after the application of appropriate adjustments to the historical experience, e.g., claims completion factors and historical policy change adjustments. These adjustments are noted in the related category of service Appendix.

<sup>3</sup>Utilization per member (UPM): Units of service per member per year. UPM is calculated as total units divided by total member months, multiplied by 12.

<sup>4</sup>Per member per month (PMPM): Monthly billed/cost per member per month. The PMPM value is calculated as billed/cost per unit multiplied times UPM and divided by 12.

Unit type(s) for the Home Health category of service: Claims.  
Sum of numbers may differ from totals due to rounding.

Transportation

Fee-for-Service Eligibility Category	Unadjusted Historical Experience <sup>1</sup>			Adjusted Historical Experience <sup>2</sup>			Historical Benchmark Rates			CY 2008-09 Benchmark Rates		
	Reimbursement per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Reimbursement per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>
AB/AD without Medicare	\$ 24.75	11.7472	\$ 30.72	\$ 24.75	11.9113	\$ 31.15	\$ 25.25	11.9113	\$ 31.77	\$ 28.74	14.0353	\$ 42.62
AB/AD with Medicare	\$ 22.43	16.6262	\$ 31.35	\$ 22.43	16.6759	\$ 31.44	\$ 22.43	16.6759	\$ 31.44	\$ 25.53	21.0841	\$ 45.26
CAWEM	\$ 304.94	0.0265	\$ 0.67	\$ 304.94	0.0269	\$ 0.68	\$ 320.19	0.0269	\$ 0.72	\$ 364.53	0.0269	\$ 0.82
PLM/CHIP/TANF <1	\$ 77.79	0.3149	\$ 5.18	\$ 77.79	0.3193	\$ 5.26	\$ 81.68	0.3193	\$ 5.52	\$ 93.00	0.3913	\$ 7.70
PLM/CHIP/TANF 1 - 5	\$ 48.92	0.1340	\$ 1.17	\$ 48.92	0.1351	\$ 1.18	\$ 50.87	0.1351	\$ 1.23	\$ 57.92	0.1655	\$ 1.72
PLM/CHIP/TANF 6 - 18	\$ 35.26	0.2778	\$ 1.39	\$ 35.26	0.2806	\$ 1.40	\$ 36.31	0.2806	\$ 1.44	\$ 41.34	0.3438	\$ 2.01
OAA without Medicare	\$ 25.00	3.1225	\$ 10.19	\$ 25.00	3.1629	\$ 10.32	\$ 25.75	3.1629	\$ 10.63	\$ 29.32	3.7270	\$ 14.26
OAA with Medicare	\$ 23.54	9.7786	\$ 19.39	\$ 23.54	9.8177	\$ 19.46	\$ 23.54	9.8177	\$ 19.46	\$ 26.81	12.4129	\$ 28.02
OHP Adults & Couples	\$ 298.42	0.1880	\$ 4.70	\$ 298.42	0.1899	\$ 4.75	\$ 313.34	0.1899	\$ 4.99	\$ 332.14	0.2185	\$ 6.08
OHP Families	\$ 256.40	0.0537	\$ 1.21	\$ 256.40	0.0542	\$ 1.22	\$ 269.22	0.0542	\$ 1.28	\$ 285.38	0.0625	\$ 1.57
PLM Adults	\$ 38.72	0.8245	\$ 4.66	\$ 38.72	0.8377	\$ 4.73	\$ 40.27	0.8377	\$ 4.92	\$ 45.84	0.9900	\$ 6.62
SCF Children	\$ 28.41	1.2051	\$ 3.40	\$ 28.41	1.2207	\$ 3.44	\$ 28.98	1.2207	\$ 3.51	\$ 32.99	1.4959	\$ 4.90
TANF Adults	\$ 26.38	1.7741	\$ 5.81	\$ 26.39	1.7953	\$ 5.88	\$ 27.18	1.7953	\$ 6.06	\$ 30.94	2.1217	\$ 8.15
Transportation Total	\$ 24.82	3.2426	\$ 7.92	\$ 24.83	3.2687	\$ 7.99	\$ 25.13	3.2687	\$ 8.11	\$ 28.50	4.0097	\$ 11.22

<sup>1</sup>Unadjusted historical experience: July 2003 through June 2005 for OHP Plus and CY 2005 for OHP Standard, based on Exhibits 3, 4, and 5 of PricewaterhouseCoopers "Analysis of Calendar Years 2008 - 2009 Average Costs," dated September 22, 2006.

<sup>2</sup>Adjusted Historical Experience: Historical experience after the application of appropriate adjustments to the historical experience, e.g., claims completion factors and historical policy change adjustments. These adjustments are noted in the related category of service Appendix.

<sup>3</sup>Utilization per member (UPM): Units of service per member per year. UPM is calculated as total units divided by total member months, multiplied by 12.

<sup>4</sup>Per member per month (PMPM): Monthly reimbursement/cost per member per month. The PMPM value is calculated as reimbursement/cost per unit multiplied times UPM and divided by 12.

Unit type(s) for the Transportation category of service: Services.

Sum of numbers may differ from totals due to rounding.

Managed Care Eligibility Group	Unadjusted Historical Experience <sup>1</sup>			Adjusted Historical Experience <sup>2</sup>			Historical Benchmark Rates			CY 2008-09 Benchmark Rates		
	Billed per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Billed per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>
AB/AD without Medicare	\$ 447.52	0.4853	\$ 18.10	\$ 447.52	0.4863	\$ 18.14	\$ 340.11	0.4863	\$ 13.78	\$ 392.76	0.5971	\$ 19.54
AB/AD with Medicare	\$ 343.90	0.3377	\$ 9.68	\$ 68.78	0.3407	\$ 1.95	\$ 52.27	0.3407	\$ 1.48	\$ 60.36	0.4072	\$ 2.05
CAWEM	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -
PLM/CHIP/TANF <1	\$ 969.23	0.1075	\$ 8.68	\$ 969.24	0.1077	\$ 8.70	\$ 736.62	0.1077	\$ 6.61	\$ 850.65	0.1302	\$ 9.23
PLM/CHIP/TANF 1 - 5	\$ 548.99	0.0396	\$ 1.81	\$ 548.99	0.0394	\$ 1.80	\$ 417.23	0.0394	\$ 1.37	\$ 481.82	0.0476	\$ 1.91
PLM/CHIP/TANF 6 - 18	\$ 494.79	0.0333	\$ 1.37	\$ 494.79	0.0332	\$ 1.37	\$ 376.04	0.0332	\$ 1.04	\$ 434.25	0.0401	\$ 1.45
OAA without Medicare	\$ 407.49	0.2757	\$ 9.36	\$ 407.49	0.2757	\$ 9.36	\$ 309.69	0.2757	\$ 7.11	\$ 357.63	0.3385	\$ 10.09
OAA with Medicare	\$ 352.86	0.5796	\$ 17.04	\$ 70.57	0.5853	\$ 3.44	\$ 53.63	0.5853	\$ 2.62	\$ 61.94	0.6996	\$ 3.61
OHP Adults & Couples	\$ 440.37	0.2392	\$ 8.78	\$ 440.38	0.2440	\$ 8.95	\$ 334.69	0.2440	\$ 6.81	\$ 356.91	0.2867	\$ 8.53
OHP Families	\$ 438.21	0.0859	\$ 3.14	\$ 438.20	0.0876	\$ 3.20	\$ 333.03	0.0876	\$ 2.43	\$ 355.15	0.0987	\$ 2.92
PLM Adults	\$ 540.79	0.1864	\$ 8.40	\$ 540.79	0.1875	\$ 8.45	\$ 411.00	0.1875	\$ 6.42	\$ 474.62	0.2161	\$ 8.55
SCF Children	\$ 539.00	0.0483	\$ 2.17	\$ 539.00	0.0482	\$ 2.17	\$ 409.64	0.0482	\$ 1.65	\$ 473.05	0.0583	\$ 2.30
TANF Adults	\$ 447.72	0.1344	\$ 5.01	\$ 447.72	0.1346	\$ 5.02	\$ 340.27	0.1346	\$ 3.82	\$ 392.94	0.1551	\$ 5.08
Transportation Total	\$ 453.93	0.1523	\$ 5.76	\$ 368.98	0.1530	\$ 4.70	\$ 280.43	0.1530	\$ 3.57	\$ 322.82	0.1837	\$ 4.94

<sup>1</sup>Unadjusted historical experience: July 2003 through June 2005 for OHP Plus and CY 2005 for OHP Standard, based on Exhibits 3, 4, and 5 of PricewaterhouseCoopers "Analysis of Calendar Years 2008 - 2009 Average Costs," dated September 22, 2006.

<sup>2</sup>Adjusted Historical Experience: Historical experience after the application of appropriate adjustments to the historical experience, e.g., claims completion factors and historical policy change adjustments. These adjustments are noted in the related category of service Appendix.

<sup>3</sup>Utilization per member (UPM): Units of service per member per year. UPM is calculated as total units divided by total member months, multiplied by 12.

<sup>4</sup>Per member per month (PMPM): Monthly billed/cost per member per month. The PMPM value is calculated as billed/cost per unit multiplied times UPM and divided by 12.

Unit type(s) for the Transportation category of service: Services.

Sum of numbers may differ from totals due to rounding.

Vision

Fee-for-Service Eligibility Category	Unadjusted Historical Experience <sup>1</sup>			Adjusted Historical Experience <sup>2</sup>			Historical Benchmark Rates			CY 2008-09 Benchmark Rates		
	Reimbursement per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Reimbursement per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>
AB/AD without Medicare	\$ 28.52	1.0303	\$ 2.45	\$ 28.52	1.0446	\$ 2.48	\$ 37.64	1.0446	\$ 3.28	\$ 41.78	1.2309	\$ 4.29
AB/AD with Medicare	\$ 21.92	0.8521	\$ 1.56	\$ 21.92	0.8547	\$ 1.56	\$ 28.06	0.8547	\$ 2.00	\$ 31.15	1.0806	\$ 2.80
CAWEM	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -
PLM/CHIP/TANF <1	\$ 42.05	0.0543	\$ 0.19	\$ 42.05	0.0550	\$ 0.19	\$ 58.45	0.0550	\$ 0.27	\$ 64.88	0.0674	\$ 0.36
PLM/CHIP/TANF 1 - 5	\$ 33.17	0.1472	\$ 0.41	\$ 33.17	0.1483	\$ 0.41	\$ 44.78	0.1483	\$ 0.55	\$ 49.70	0.1818	\$ 0.75
PLM/CHIP/TANF 6 - 18	\$ 27.90	0.7296	\$ 1.70	\$ 27.90	0.7368	\$ 1.71	\$ 36.55	0.7368	\$ 2.24	\$ 40.58	0.9029	\$ 3.05
OAA without Medicare	\$ 27.86	1.1063	\$ 2.57	\$ 27.86	1.1206	\$ 2.60	\$ 36.78	1.1206	\$ 3.43	\$ 40.83	1.3204	\$ 4.49
OAA with Medicare	\$ 22.04	0.5678	\$ 1.04	\$ 22.04	0.5700	\$ 1.05	\$ 28.22	0.5700	\$ 1.34	\$ 31.32	0.7207	\$ 1.88
OHP Adults & Couples	\$ 55.77	0.1587	\$ 0.74	\$ 55.77	0.1603	\$ 0.75	\$ 79.19	0.1603	\$ 1.06	\$ 85.43	0.1845	\$ 1.31
OHP Families	\$ 57.73	0.0826	\$ 0.40	\$ 57.73	0.0835	\$ 0.40	\$ 81.98	0.0835	\$ 0.57	\$ 88.43	0.0962	\$ 0.71
PLM Adults	\$ 25.65	0.5709	\$ 1.22	\$ 25.64	0.5801	\$ 1.24	\$ 33.59	0.5801	\$ 1.62	\$ 37.29	0.6855	\$ 2.13
SCF Children	\$ 27.46	0.6871	\$ 1.57	\$ 27.46	0.6960	\$ 1.59	\$ 36.25	0.6960	\$ 2.10	\$ 40.24	0.8529	\$ 2.86
TANF Adults	\$ 27.95	0.9528	\$ 2.22	\$ 27.95	0.9642	\$ 2.25	\$ 36.61	0.9642	\$ 2.94	\$ 40.64	1.1395	\$ 3.86
Vision Total	\$ 26.81	0.5239	\$ 1.17	\$ 26.82	0.5288	\$ 1.18	\$ 35.14	0.5288	\$ 1.55	\$ 38.87	0.6452	\$ 2.09

<sup>1</sup>Unadjusted historical experience: July 2003 through June 2005 for OHP Plus and CY 2005 for OHP Standard, based on Exhibits 3, 4, and 5 of PricewaterhouseCoopers "Analysis of Calendar Years 2008 - 2009 Average Costs," dated September 22, 2006.

<sup>2</sup>Adjusted Historical Experience: Historical experience after the application of appropriate adjustments to the historical experience, e.g., claims completion factors and historical policy change adjustments. These adjustments are noted in the related category of service Appendix.

<sup>3</sup>Utilization per member (UPM): Units of service per member per year. UPM is calculated as total units divided by total member months, multiplied by 12.

<sup>4</sup>Per member per month (PMPM): Monthly reimbursement/cost per member per month. The PMPM value is calculated as reimbursement/cost per unit multiplied times UPM and divided by 12.

Unit type(s) for the Vision category of service: CPT Code Units.  
Sum of numbers may differ from totals due to rounding.

Managed Care Eligibility Group	Unadjusted Historical Experience <sup>1</sup>			Adjusted Historical Experience <sup>2</sup>			Historical Benchmark Rates			CY 2008-09 Benchmark Rates		
	Billed per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Billed per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>
AB/AD without Medicare	\$ 49.18	1.3093	\$ 5.37	\$ 49.18	1.3119	\$ 5.38	\$ 42.29	1.3119	\$ 4.62	\$ 47.11	1.6107	\$ 6.32
AB/AD with Medicare	\$ 48.17	1.2632	\$ 5.07	\$ 48.17	1.2745	\$ 5.12	\$ 41.43	1.2745	\$ 4.40	\$ 46.14	1.5233	\$ 5.86
CAWEM	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -
PLM/CHIP/TANF <1	\$ 109.34	0.0423	\$ 0.39	\$ 109.35	0.0424	\$ 0.39	\$ 98.41	0.0424	\$ 0.35	\$ 109.61	0.0512	\$ 0.47
PLM/CHIP/TANF 1 - 5	\$ 50.95	0.1998	\$ 0.85	\$ 50.95	0.1988	\$ 0.84	\$ 44.33	0.1988	\$ 0.73	\$ 49.38	0.2404	\$ 0.99
PLM/CHIP/TANF 6 - 18	\$ 41.97	0.9922	\$ 3.47	\$ 41.97	0.9882	\$ 3.46	\$ 36.10	0.9882	\$ 2.97	\$ 40.20	1.1948	\$ 4.00
OAA without Medicare	\$ 55.53	1.4566	\$ 6.74	\$ 55.53	1.4566	\$ 6.74	\$ 47.76	1.4566	\$ 5.80	\$ 53.19	1.7884	\$ 7.93
OAA with Medicare	\$ 57.24	1.2363	\$ 5.90	\$ 57.24	1.2486	\$ 5.96	\$ 49.80	1.2486	\$ 5.18	\$ 55.47	1.4923	\$ 6.90
OHP Adults & Couples	\$ 110.11	0.1473	\$ 1.35	\$ 110.11	0.1502	\$ 1.38	\$ 99.10	0.1502	\$ 1.24	\$ 107.15	0.1765	\$ 1.58
OHP Families	\$ 98.77	0.0730	\$ 0.60	\$ 98.76	0.0745	\$ 0.61	\$ 88.89	0.0745	\$ 0.55	\$ 96.11	0.0839	\$ 0.67
PLM Adults	\$ 41.30	1.0626	\$ 3.66	\$ 41.30	1.0690	\$ 3.68	\$ 35.10	1.0690	\$ 3.13	\$ 39.10	1.2319	\$ 4.01
SCF Children	\$ 41.98	1.1553	\$ 4.04	\$ 41.98	1.1541	\$ 4.04	\$ 36.10	1.1541	\$ 3.47	\$ 40.21	1.3954	\$ 4.68
TANF Adults	\$ 43.29	1.1144	\$ 4.02	\$ 43.29	1.1166	\$ 4.03	\$ 36.80	1.1166	\$ 3.42	\$ 40.98	1.2868	\$ 4.39
Vision Total	\$ 46.13	0.8191	\$ 3.15	\$ 46.15	0.8196	\$ 3.15	\$ 39.72	0.8196	\$ 2.71	\$ 44.23	0.9821	\$ 3.62

<sup>1</sup>Unadjusted historical experience: July 2003 through June 2005 for OHP Plus and CY 2005 for OHP Standard, based on Exhibits 3, 4, and 5 of PricewaterhouseCoopers "Analysis of Calendar Years 2008 - 2009 Average Costs," dated September 22, 2006.

<sup>2</sup>Adjusted Historical Experience: Historical experience after the application of appropriate adjustments to the historical experience, e.g., claims completion factors and historical policy change adjustments. These adjustments are noted in the related category of service Appendix.

<sup>3</sup>Utilization per member (UPM): Units of service per member per year. UPM is calculated as total units divided by total member months, multiplied by 12.

<sup>4</sup>Per member per month (PMPM): Monthly billed/cost per member per month. The PMPM value is calculated as billed/cost per unit multiplied times UPM and divided by 12.

Unit type(s) for the Vision category of service: CPT Code Units.  
Sum of numbers may differ from totals due to rounding.



Not Elsewhere Classified

Fee-for-Service Eligibility Category	Unadjusted Historical Experience <sup>1</sup>			Adjusted Historical Experience <sup>2</sup>			Historical Benchmark Rates			CY 2008-09 Benchmark Rates		
	Reimbursement per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Reimbursement per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>
AB/AD without Medicare	\$ 108.69	1.7329	\$ 21.54	\$ 108.69	1.7571	\$ 21.84	\$ 163.61	1.7571	\$ 32.88	\$ 181.15	2.0704	\$ 42.89
AB/AD with Medicare	\$ 171.11	0.0660	\$ 1.07	\$ 171.11	0.0662	\$ 1.08	\$ 257.56	0.0662	\$ 1.62	\$ 285.18	0.0837	\$ 2.27
CAWEM	\$ 53.03	0.0001	\$ 0.00	\$ 48.44	0.0001	\$ 0.00	\$ 72.92	0.0001	\$ 0.00	\$ 80.74	0.0001	\$ 0.00
PLM/CHIP/TANF <1	\$ 239.80	0.7907	\$ 15.72	\$ 239.79	0.8018	\$ 15.94	\$ 360.96	0.8018	\$ 23.99	\$ 399.66	0.9826	\$ 32.56
PLM/CHIP/TANF 1 - 5	\$ 183.23	0.1940	\$ 2.91	\$ 183.22	0.1956	\$ 2.93	\$ 275.81	0.1956	\$ 4.41	\$ 305.37	0.2397	\$ 5.99
PLM/CHIP/TANF 6 - 18	\$ 100.32	0.0904	\$ 1.06	\$ 100.34	0.0913	\$ 1.07	\$ 151.05	0.0913	\$ 1.61	\$ 167.24	0.1118	\$ 2.18
OAA without Medicare	\$ 634.96	0.0186	\$ 1.81	\$ 634.99	0.0188	\$ 1.83	\$ 955.85	0.0188	\$ 2.76	\$ 1,058.31	0.0222	\$ 3.60
OAA with Medicare	\$ 2,033.37	0.0096	\$ 1.77	\$ 2,033.30	0.0096	\$ 1.78	\$ 3,060.73	0.0096	\$ 2.67	\$ 3,388.84	0.0122	\$ 3.74
OHP Adults & Couples	\$ 155.35	0.1259	\$ 2.20	\$ 155.34	0.1271	\$ 2.23	\$ 233.83	0.1271	\$ 3.35	\$ 253.36	0.1463	\$ 4.18
OHP Families	\$ 160.84	0.0466	\$ 0.75	\$ 160.83	0.0471	\$ 0.75	\$ 242.10	0.0471	\$ 1.14	\$ 262.32	0.0542	\$ 1.42
PLM Adults	\$ 140.66	2.4217	\$ 27.68	\$ 140.66	2.4604	\$ 28.13	\$ 211.74	2.4604	\$ 42.34	\$ 234.44	2.9079	\$ 55.40
SCF Children	\$ 139.66	0.8181	\$ 11.59	\$ 139.66	0.8287	\$ 11.74	\$ 210.23	0.8287	\$ 17.67	\$ 232.77	1.0155	\$ 23.97
TANF Adults	\$ 145.87	0.4047	\$ 5.18	\$ 145.87	0.4095	\$ 5.25	\$ 219.58	0.4095	\$ 7.90	\$ 243.12	0.4840	\$ 10.33
Other Services Total	\$ 144.66	0.3922	\$ 5.49	\$ 144.62	0.3974	\$ 5.56	\$ 217.69	0.3974	\$ 8.36	\$ 242.23	0.4752	\$ 11.13

<sup>1</sup>Unadjusted historical experience: July 2003 through June 2005 for OHP Plus and CY 2005 for OHP Standard, based on Exhibits 3, 4, and 5 of PricewaterhouseCoopers "Analysis of Calendar Years 2008 - 2009 Average Costs," dated September 22, 2006.

<sup>2</sup>Adjusted Historical Experience: Historical experience after the application of appropriate adjustments to the historical experience, e.g., claims completion factors and historical policy change adjustments. These adjustments are noted in the related category of service Appendix.

<sup>3</sup>Utilization per member (UPM): Units of service per member per year. UPM is calculated as total units divided by total member months, multiplied by 12.

<sup>4</sup>Per member per month (PMPM): Monthly reimbursement/cost per member per month. The PMPM value is calculated as reimbursement/cost per unit multiplied times UPM and divided by 12.

Unit type(s) for the Other Services category of service: Services, Admits, or Claims.

Sum of numbers may differ from totals due to rounding.

Managed Care Eligibility Group	Unadjusted Historical Experience <sup>1</sup>			Adjusted Historical Experience <sup>2</sup>			Historical Benchmark Rates			CY 2008-09 Benchmark Rates		
	Billed per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Billed per Unit	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>	Unit Cost	UPM <sup>3</sup>	PMPM <sup>4</sup>
AB/AD without Medicare	\$ 2,881.55	0.0205	\$ 4.92	\$ 2,881.53	0.0205	\$ 4.93	\$ 1,828.91	0.0205	\$ 3.13	\$ 2,039.23	0.0252	\$ 4.29
AB/AD with Medicare	\$ 3,131.55	0.0006	\$ 0.15	\$ 0.00	0.0006	\$ 0.00	\$ 0.00	0.0006	\$ 0.00	\$ 0.00	0.0007	\$ 0.00
CAWEM	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -	\$ -	0.0000	\$ -
PLM/CHIP/TANF <1	\$ 2,787.65	0.0004	\$ 0.09	\$ 2,786.90	0.0004	\$ 0.10	\$ 2,680.16	0.0004	\$ 0.09	\$ 2,988.38	0.0005	\$ 0.12
PLM/CHIP/TANF 1 - 5	\$ 3,774.15	0.0000	\$ 0.01	\$ 3,760.66	0.0000	\$ 0.01	\$ 3,275.91	0.0000	\$ 0.01	\$ 3,652.64	0.0000	\$ 0.01
PLM/CHIP/TANF 6 - 18	\$ 1,343.67	0.0000	\$ 0.00	\$ 1,335.65	0.0000	\$ 0.00	\$ 1,080.81	0.0000	\$ 0.00	\$ 1,205.10	0.0001	\$ 0.00
OAA without Medicare	\$ 2,689.44	0.0535	\$ 12.00	\$ 2,689.45	0.0535	\$ 12.00	\$ 1,378.07	0.0535	\$ 6.15	\$ 1,536.55	0.0657	\$ 8.42
OAA with Medicare	\$ 3,138.15	0.0095	\$ 2.49	\$ 0.00	0.0096	\$ 0.00	\$ 0.00	0.0096	\$ 0.00	\$ 0.00	0.0115	\$ 0.00
OHP Adults & Couples	\$ 2,738.96	0.0029	\$ 0.65	\$ 2,738.79	0.0029	\$ 0.65	\$ 2,288.26	0.0029	\$ 0.55	\$ 2,489.17	0.0034	\$ 0.70
OHP Families	\$ 1,584.00	0.0005	\$ 0.07	\$ 1,583.37	0.0005	\$ 0.07	\$ 1,157.44	0.0005	\$ 0.05	\$ 1,259.06	0.0006	\$ 0.06
PLM Adults	\$ 0.00	0.0000	\$ 0.00	\$ 0.00	0.0000	\$ 0.00	\$ 0.00	0.0000	\$ 0.00	\$ 0.00	0.0000	\$ 0.00
SCF Children	\$ 1,581.15	0.0002	\$ 0.03	\$ 1,580.98	0.0002	\$ 0.03	\$ 1,585.56	0.0002	\$ 0.03	\$ 1,767.90	0.0003	\$ 0.04
TANF Adults	\$ 2,838.82	0.0005	\$ 0.12	\$ 2,838.88	0.0005	\$ 0.12	\$ 2,089.70	0.0005	\$ 0.09	\$ 2,330.02	0.0006	\$ 0.12
Other Services Total	\$ 2,900.32	0.0029	\$ 0.71	\$ 2,349.06	0.0030	\$ 0.58	\$ 1,511.04	0.0030	\$ 0.37	\$ 1,688.79	0.0036	\$ 0.51

<sup>1</sup>Unadjusted historical experience: July 2003 through June 2005 for OHP Plus and CY 2005 for OHP Standard, based on Exhibits 3, 4, and 5 of PricewaterhouseCoopers "Analysis of Calendar Years 2008 - 2009 Average Costs," dated September 22, 2006.

<sup>2</sup>Adjusted Historical Experience: Historical experience after the application of appropriate adjustments to the historical experience, e.g., claims completion factors and historical policy change adjustments. These adjustments are noted in the related category of service Appendix.

<sup>3</sup>Utilization per member (UPM): Units of service per member per year. UPM is calculated as total units divided by total member months, multiplied by 12.

<sup>4</sup>Per member per month (PMPM): Monthly billed/cost per member per month. The PMPM value is calculated as billed/cost per unit multiplied times UPM and divided by 12.

Unit type(s) for the Other Services category of service: Services, Admits, or Claims.

Sum of numbers may differ from totals due to rounding.

## Appendix J

## Glossary

Term	Definition
AB/AD (Aid to Blind /Aid to Disabled)	Medicaid population consisting of blind and disabled individuals. Eligibility is also determined by income as a percent of the FPL.
AMP (Average Manufacturer Price)	Per the Medicaid Rebate Act, AMP represents the average price received by the manufacturer for the drug in the United States from wholesalers for drugs distributed to the retail pharmacy class of trade.
AWP (Average Wholesale Price)	A price of prescription drugs, which is supposed to represent the average price at which wholesalers sell drugs to pharmacies and other providers. The AWP is published by commercial publishers of drug pricing data and is based on information provided by manufacturers.
Capitation	The payment per capita for a defined package of services. A specific amount per member is paid to managed care plans, providers, or organizations of providers regardless of the quantity of services provided.
CAWEM (Citizen Alien Waived Emergency Medical)	A population that does not qualify for Medicaid based on their alien status. This population receives a limited set of services, restricted to emergency situations, which includes labor and delivery.
CCR (Cost-to-Charge Ratio)	A factor used to convert the amount billed for a health service to an approximation of the cost of providing that service based on historical financial data.
CMS (Centers for Medicare & Medicaid Services)	The federal agency that oversees and partially finances state Medicaid programs.
CPT (Current Procedural Terminology)	A medical codeset of physician and other services, maintained and copyrighted by the American Medical Association (AMA), and adopted by the Secretary of HHS as the standard for reporting physician and other services on standard transactions.

Term	Definition
COS (Category of Service)	One of nine major service types for which benchmark rates were established. They are Hospital, Professional Services (including Physician), Prescription Drugs, Inpatient Mental Health, Outpatient Mental Health, Chemical Dependency, DME/Supplies, Dental Services, and Other Services.
DME (Durable Medical Equipment)	Equipment which can stand repeated use and is used for medical purposes.
DRG (Diagnostic Related Group)	The classification of patients into clinically cohesive groups that demonstrate similar consumption of hospital resources and length of stay patterns.
DSH (Disproportionate Share Hospital)	Funds allocated to hospitals with a larger amount of indigent patients.
FPL (Federal Poverty Level)	A national benchmark of poverty status based on income level that is maintained by CMS.
FFS (Fee-for-Service)	Traditional provider reimbursement in which provider is paid according to the service performed. This is the reimbursement system used by conventional indemnity insurers.
HCPCS (Health Care Common Procedure Coding System)	A system that provides for a uniform method for health care providers and medical suppliers to report professional services, procedures, and supplies. The system includes three levels for reporting: 1—CPT; 2—HCPCS/National Codes; and 3—Local Codes (eliminated as of 12/31/03).
HIPAA (Health Insurance Portability & Accountability Act)	Federal regulations establishing national standards for health care information.
Managed Care	An array of cost-containment/quality assurance techniques, such as full or partial capitation to providers, explicit standards for selecting participating providers, preadmission certification, or other forms of utilization management designed to reduce the inappropriate use of health care services and to improve overall quality of care. Includes Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Point-of-Service (POS) plans, and Primary Care Case Manager (PCCM) programs.
Medicare Cost Reports	Filings from hospitals and certain other facilities presenting their costs according to Provider Reimbursement Manual (HIM-15) guidelines.
Member Months	A count which records one member month for each month the member is eligible for Medicaid services.
NDC (National Drug Code)	The national classification system for identifying prescription drugs.
OAA (Old Age Assistance)	Medicaid population consisting of individuals over age 65. Eligibility is also determined by income as a percent of the FPL.
OHP (Oregon Health Plan)	The Oregon Medicaid Demonstration programs, consisting of the OHP Plus and OHP Standard populations.

Term	Definition
OHP Plus	That portion of the Oregon Medicaid Demonstration consisting of the “categorically eligible” or “traditional Medicaid” populations (AB/AD, OAA, PLM, SCF, and TANF) whose coverage is mandated by Medicaid, plus those children covered under SCHIP. These populations receive the full benefit package defined by the legislatively funded portion of the Health Services Commission’s Prioritized List of Health Services.
OHP Standard	The expansion population that is covered by OHP as a result of the Oregon Medicaid Demonstration. They consist of optional Medicaid populations representing parents and adults/couples who do not meet the requirements of categorical eligibility (including income limits). These populations receive the OHP Plus benefit package, further reduced by limitations or exclusions of optional Medicaid services (e.g., vision, dental, DME, non-emergent transportation) not funded by the legislature.
PLM (Poverty Level Medical)	Medicaid population consisting of pregnant women and children. Eligibility is also determined by income as a percent of the FPL.
PMPM (Per Member Per Month)	A cost measurement related to each enrollee for each month of eligibility.
PWC (PricewaterhouseCoopers)	The actuarial firm contracted by the Department of Human Services to establish capitation rates for the Oregon Health Plan.
SCHIP (State Children’s Health Insurance Program)	Title XXI of the Supplemental Security Act. Appropriation of \$21 billion to cover health costs for children up to 200% FPL or 50 percentage points above state’s current FPL level. State matches funds by using enhanced matching rate and state determines criteria of eligibility.
SCF (Services for Children and Families)	Medicaid population consisting of children age 18 and younger (some up to age 21) who are in the legal custody of the Department of Human Services and placed outside their parental home.
TANF (Temporary Aid to Needy Families)	Medicaid population consisting of single parent families with children and two-parent families when the primary wage earner is unemployed. Eligibility is also determined by income as a percent of the FPL.
TPL (Third Party Liability)	A category under which insurance providers are billed for medical expenses incurred by recipients of public assistance who have medical insurance in addition to coverage provided through public assistance. In these cases, the state pays the difference between the amount of the medical bill and the amount the insurance company has paid.
Trend	The adjustment for medical inflation from a historical period to a more recent/future period (usually stated in an annual number).

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