DMAP 11/15/07

OHP Rate Trending Background and Issues
DRAFT

Summary of Discussion at October 16 PAP Meeting

Judy Mohr Peterson summarized the trending component of rate setting as currently practiced. She referred the PAP to the description of physician cost trending in the PwC report on Per Capita Costs, noting that the utilization trends are based on OHP encounter data that are 3-5 years old by the time we make capitation payments based on these data. She also noted that PwC uses external trend factors provided by CMS, including Medicare trend factors, and Ed Deery added that PwC also uses a variety of external sources for trend information. Judy also noted that in the absence of paid claims data, PwC needs Medicare and commercial cost data, and also needs to factor in the Medicaid experience of other states.

Questions and comments on trending included the following:

- Where in the range of trend factor values does PwC select the value to be used in developing per capita costs, and what criteria are used in selecting this value?
- How does PwC go beyond Medicare and other CMS information to supplement OHP encounter data in developing trend factors?
- Budget-balancing measures shouldn't supplant policy factors in determining trend factors – how is this safeguarded against currently?
- Estimating costs of care should be kept independent of budget and legislative decisions.
- PwC has appeared in the past to ignore the fact that in some cases, billed charges are less than the cost of care.
- The PwC process is very mathematical, and we need to find a way to go beyond strict mathematics to smooth out rate changes resulting from annual ups and downs.
- How are new technologies accounted for in the trend? Ed Deery noted that the trend rates reflect new technology, along with all the other

drivers of utilization and cost per unit of service. Ed also noted that new technology often decreases costs and improves outcomes.

- The medical CPI could be used to reflect emerging technologies and other changes affecting costs
- What sort of feedback loop does PwC use to identify areas where its trend prediction assumptions were mistaken and to make corrections to those assumptions?
- Lynn Read was unable to attend the meeting, but she added a policy regarding risk: How should DHS address the financial risk to contracting health plans and to the state that can result from trending?

Judy closed her presentation by asking for additional suggestions or comments from PAP members through PAP staff.

PwC Description of Trending of Per Capita Costs From 2006 to 2008/09[1]

The per capita costs developed in our September 2006 report were calculated to cover the two year time period of January 2008 through December 2009. The trend rates presented in the per capita cost development report have been used to develop statewide capitation rates for the Calendar Year 2008 contract period.

Trend adjustments for all managed care plan types are calculated using the trending methodology that has been used in the development of prior capitation rates. Specifically, the trend rates that were applied in the per capita cost development are used to move the projected costs from the midpoint of the two year period (January 1, 2009) to the midpoint of the contract period (July 1, 2008). The trend adjustments can be found in Exhibit 2-A.

[1] Capitation Rate Development January 2008- December 2008;October 2007;PwC; Section III, p.6

Method for Trending Data Forward to FFY 2006-2007[2]

The cost per unit of service for all categories of service is trended forward to reflect the projection period of Oct. 1, 2005 through Sept. 30, 2007. Total trend rates are made up of two components:

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

The trend rates in this analysis are calculated using two different approaches to reflect the differences in contracting arrangements and payment rates under the OHP. Separate trend rates are developed for discrete eligibility groups that may experience variation in the rate of change in costs and utilization, including TANF and related adults, OHP Standard, Children, and Disabled/OAA eligibles with and without Medicare coverage.

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

1. Information reported by CMS Office of the Actuary in their research on the change in cost of health care services,
2. Information reported by CMS on actual Medicare reimbursement changes,
3. Regression models based on managed care plan encounter date and fee—for-service claims data that measure rates of change in utilization of services, costs, per unit of service, and costs per member month, subset by major eligibility category and service type; and
4. Published reports on expected rates of change in per capita costs for prescription drugs.

Where CMS data are used, we have generally applied the measure of expected change in the "commercial" portion of the CMS report. For managed care dental services, the "total" (all payer) CMS expenditures information is used, as dental services have a higher level of patient copay requirement in commercial plans than would be experienced in the OHP.

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[2] Analysis of Federal Fiscal Years 2006-2007 Average Costs; March 7, 2005; PwC; Section III, p. 29

The utilization trends are adjusted to reflect observed trends for inpatient, outpatient, and physician services.

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

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

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

Oregon Health Plan Medicaid Demonstration

EXHIBIT 2-A

Capitation Rate Development for January 2008 through December 2008
Trend Adjustments

TANF RELATED ADULTS [1]	Annualized Trend Rates [2]	Trend Adjustment [3]
Inpatient Hospital	3.4%	0.983
Outpatient Hospital	3.4%	0.983
Physician & Other	5.7%	0.973
Prescription Drug	7.7%	0.963
Dental	6.2%	0.970
Mental Health/CD	5.9%	0.972

CHILDREN	Annualized Trend Rates [2]	Trend Adjustment [3]
Inpatient Hospital	3.4%	0.983
Outpatient Hospital	7.9%	0.962
Physician & Other	6.4%	0.970
Prescription Drug	7.7%	0.963
Dental	6.2%	0.970
Mental Health/CD	8.6%	0.960

DISABLED-RELATED [1]	Annualized Trend Rates [2]	Trend Adjustment [3]
Inpatient Hospital	7.9%	0.962
Outpatient Hospital	7.9%	0.962
Physician & Other	6.6%	0.969
Prescription Drug	7.7%	0.963
Dental	6.2%	0.970
Mental Health/CD	2.8%	0.986

DUAL MEDICAID/MEDICARE ELIGIBILITY CATEGORIES [1]	Annualized Trend Rates [2]	Trend Adjustment [3]
Inpatient Hospital	0.0%	1.000
Outpatient Hospital	7.9%	0.962
Physician & Other	6.2%	0.970
Prescription Drug	7.7%	0.963
Dental	6.2%	0.970
Mental Health/CD	5.9%	0.972

[1] TANF-Related Adult factors apply to the TANF, PLMA, and OHPFAM eligibility categories.
Disabled-Related factors apply to the AB/AD without Medicare, OAA without Medicare, and OHPAC eligibility categories.
Dual-Medicaid/Medicare factors apply to the AB/AD with Medicare and OAA with Medicare eligibility categories.

[2] Annualized trend rates from Exhibit 7-A of "Oregon Health Plan Medicaid Demonstration:
Analysis of Calendar Years 2008 - 2009 Average Costs" dated September 22, 2006.

[3] Trend factors used to adjust capitation rates from midpoint of biennium (1/1/2009) to midpoint of contract period (7/1/2008).