

Actuarial Services Unit

Rate Setting Issues Subcommittee

Building a successful foundation
December 2006

Based on the presentation by PricewaterhouseCoopers to the OHP rates and actuarial work group in March of 2006, the Actuarial Services Unit (ASU) has compiled a list of considerations for subcommittee involvement and/or DHS, DMAP and AMH policy decisions. The following represents the key assumptions and methods for success, per capita cost (PCC) development considerations, followed by capitation rate assumptions. This list is not exhaustive and can be added to upon review.

Key assumptions and methods for success

Key areas for consideration for subcommittee involvement are:

- Data period trend
- Projection period trend
- Relationship between charges and costs – definitions and factors;
- Effect of program changes on per capita and total program costs; and
- Administrative cost analysis.

To be successful, a partnership between ASU, actuary and Stakeholders to:

- Validate calculations;
- Review mathematical calculations and theoretical rate development issues;
- Provide information on non-encountered data that should be incorporated into PCC analysis;
- Review draft results and provide timely comments so concerns/issues can be addressed for inclusion in development of PCC;
- Provide requested information and assist in interpretation upon request of DHS; and
- Meet key dates and time lines.

Per Capita Cost (PCC) Development 2009-2011

The PCC development is broken out into the following categories: Assumptions, data sources, ensuring accuracy, converting charges to costs, data adjustments and key dates and time lines.

Assumptions:

- The relationship between average charge amounts and the implied cost per unit of providing services; paid data are not provided by the managed care plans so estimates are needed.
- Adjustments to data from the data period to the projection period (trend, changes in coverage rules).

- The distribution of the population among different groups of people who will be participating in the program.
- Enrollment in capitated plans (Fully Capitated Health Plans (FCHPs), Dental Care Organizations (DCOs), Chemical Dependency Organizations (CDOs), Physician Care Organizations (PCOs), and Mental Health Organizations (MHOs).
- Payment policy under the Oregon Health Plan (OHP) as actual payment amount, actuarial soundness, or something else that can be signed off by the actuary for compliance with federal regulations.

Data sources:

- Encounter and other data reported to Department of Human Services (DHS) Electronic Encounter Data Unit (EEDU).
- *FCHP Prescription Drug Data* reported to DHS by FCHPs.
- Oregon Medicaid Management Information System (MMIS) Fee for Service (FFS) Data.
- Addictions and Mental Health databases (AMH) for certain mental health services that are not available in Medicaid Management Information System (MMIS).
- Eligibility data from MMIS.
- Industry sources and commercial databases.
- Base data is adjusted to reflect changes during and after the data period and to update the Per Member Per Month (PMPM) values to the 2009-2011 biennium.
- Hospital cost data provided by DMAP.
- Trend data from the Center for Medicare and Medicaid Services (CMS), and other sources.
- Programmatic changes (“Budget Issues”) - provided by DMAP and Finance and Policy Analysis (FPA)-DMAP budget.

Ensuring Accuracy:

- Data from different sources are mutually exclusive so PMPM values can be added; definition of units is sometimes different.
- Per capita costs are developed for each component of the calculation
 - Encounter data are used for calculating value of capitated services; and
 - FFS data are used to calculate comparable rates for services paid on FFS basis.
- Health plans review their own data for accuracy and identify any issues through the EEDU process of validating data and receive reports from ASU quarterly and annually for rate development.
- If there is a case of missing data, potentially partial data periods with appropriate adjustments may be used given actuarially discretion.

Converting charges to costs:

- Inpatient and outpatient hospital services
 - Use DMAP Medicare audited hospital cost reports for most recent time period.
- Physician and other professional services

- Historically PwC has used Medicare Resource Based Relative Value Scale (RBRVS) fee schedule as guideline.
- Historically, PwC has adjusted for significant changes in FFS payment rates, such as increases related to malpractice expense.
- Transportation, DME, Home Health
 - Historically PwC has used the Medicare payment methodology.
- Dental
 - Assess billed charges at the unit code level v. Medicaid FFS; determine whether all plans are reporting comparable information.
 - Medicaid FFS used as the floor.
- Prescription drugs – Expected methodology, subject to review
 - Encounter records priced at FFS payment levels including ingredient cost & dispensing fee.
 - Survey plans to obtain information on difference between FFS and FCHP cost for drugs.
- Mental Health Services
 - Review cost allocation reports generated by plans.
 - Compare results to FFS payment rates.
 - Consider Children’s intensive services (ITS).
 - Consider Prevention, Education and Outreach (PE&O) costs and determine which can be counted as medical v. administrative expense per federal regulation.
 - Significant changes in AMH contracted services have historically complicated rate development.
 - Need to segregate traditional cost/bed-day based payment rates from capitated services.
 - Consider changes in responsibility for high-cost cases.

Data Adjustments:

- IBNR
 - FFS – Measured from data using claims lag models.
 - Encounter – Obtain information from DHS regarding claims reported after data cutoff date.
- Missing Data
- Duplicate claims and encounters
 - ASU identifies and removes (flags) duplicate claims in encounter database
 - Further check is made for:
 - Duplicate claims between FCHPs and MHOs for hospital services; and
 - Duplicate claims between FFS and managed care plans.
- Budget issues resulting in changes in covered services due to legislative, policy or Health Services Commission (HSC) action.
 - Work with DHS to understand changes in payment/coverage.
 - Dollar value of change typically developed by DHS staff.
 - PwC will calculate factors representing the percent change HSC list:

- Costs are allocated to the lines of the Prioritized List
- Separate allocations are made by eligibility category and broad service category (physical health, dental, chemical dependency and mental health)
- Trend
 - PMPM change measured from the midpoint of the data period to the midpoint of biennium period (July 1, 2006 through December 31, 2010).
 - *Cost trend* is the increase in cost per unit of service.
 - *Utilization trend*
 - the increase in the number of units of service provided;
 - the relative intensity of services provided; and
 - level of new technology used to provide services.
 - Multiple sources of information for trend development
 - Encounter and FFS data – primary source;
 - Centers for Medicare and Medicaid Services Office of the Actuary;
 - Stakeholder input; and
 - Industry reports.
 - Examine encounter and FFS data to measure rates of change during the data period.
 - Units per 1000 members per month;
 - Billed and paid per person per month (where paid data are available); and
 - Billed and paid per unit of service.
 - Use data smoothing techniques to adjust for data anomalies.
 - Choose trend values for data period and projection period.
 - For some services DHS data are used for both values, for others a combination of DHS, CMS, and industry data are used based on actuarial judgment.
 - Only utilization trend can be calculated from encounter data; cost trend must be derived from other sources because paid data are not reported.
 - Generally, where regression line is smooth and data anomalies are minimal, DHS data is used, otherwise use other sources.
 - Ask for input and documentation from stakeholders on most recent trends.
- Mental Health – non-encountered services – generally Prevention, Education & Outreach:
 - Determine services provided to individuals v. community-based services; and
 - Require AMH report on expenditures, match to CMS requirements.

Key dates and time lines:

(To be determined by time line subcommittee and inserted)

Capitation Rate Development

Capitation rates for the contract calendar years are based from the 2009-2011 per capita cost development. The following issues for consideration are the same for both Year 1 and Year 2 (CY 2010 and CY 2011, respectively), unless noted.

- Trend
 - The per capita costs which form the foundation of the capitation rates are trended to the mid-point of the biennium. For each contract year's capitation rates, the per capita cost trend is adjusted to the mid-point of the year.
- Plan-specific capitation rates start with statewide values, then several adjustments are made:
- CDPS and MH risk adjustment:
 - Receive more current data to calculate risk assessment values;
 - Measures differences in expected costs by plan based on health status of plan enrollees;
 - CDPS is calculated and applied for nearly all eligibility categories; and
 - CDPS-like tool for Mental Health services was created and implemented beginning 2004.
- Newborn prevalence adjustment for Temporary Assistance for Needy Families (TANF) and OHP Families:
 - Newborn factor measures relative prevalence of babies born into plan to recognize cost differences; and
 - Factor applies only to Children 0-1 rate group.
- Hospital-specific geographic factors;
- Behavioral Rehabilitation Services (BRS) adjustment for MHOs.
 - BRS adjustment applies to MHO contracts and reflects expansions in programs.
- Children's Intensive Mental Health services (ITS) rebasing
 - Children's ITS considers numbers of children expected to be served by MHOs and policy rules regarding eligibility and responsibility.
- Maternity Case Rate.
 - Costs associated with maternities are removed from the capitation rates and paid on a case rate basis. For this reason, no maternity risk adjustment is necessary.
- Inpatient hospital factor:
 - For DRG hospitals, measures differences in input costs by region as defined by Medicare;
 - For A & B hospitals, measures differences in cost per unit as measured by hospital cost reports and tracks to individual health plans; investigating recent federal rule change that may affect calculation and settlement; and
 - Special adjustment is made for out-of-area utilization to recognize difference in intensity of services.

- Final capitation rates are calculated for each plan and geographic area, as the adjustment factors vary by area (except CDPS).
- If plan coverage area changes, capitation rates also change to reflect new population.
- Non-participating provider (non-par) rates calculated and posted to website and rule filed.
 - Methodology developed through 18-month stakeholder workgroup process;
 - Applies to DRG hospitals only;
 - Uses the same data used for capitation rate development; include DRG hospital data only, exclude records for Dual eligibles;
 - Raw data are adjusted for trend and cost to charge ratio;
 - Count number of inpatient days:
 - For capitation rates, use PMPM values only; day and admit counts do not enter directly into cap rate development.
 - Divide adjusted total costs by day count to calculate implied cost per day, reduced by 7.5%;
 - Apply hospital geographic factor;
 - For hospitals with a large number of out-of-area patients, calculate a separate payment rate for out-of-area adjustment (OOA);
 - Sum of dollars used in non-par rate equals sum of capitation dollars after excluding A/B hospitals and Dual eligibles prior to 7.5% adjustment; and
 - Outpatient non-par requirement is to pay at adjusted cost-to-charge ratio
 - Hospital-specific ratio provided by DHS;
 - Adjusted for difference between assumed cost trend and actual hospital-specific cost trend; and
 - Reduced by 7.5%.

Key dates and time lines:

(To be determined by time line subcommittee and inserted)

Topics proposed by workgroup:

- Administrative Costs;
- ENCC calculation;
- Exhibit K calculation;
- Data deadlines. Do the plan what to change the PCC data set to allow additional time for reviewing the final quarter's data.