

to: **Ed Deery** date: **October 30, 2003**  
from: **Pete Davidson** subject: **Non-contracted DRG  
Hospital Base Rates**

This memorandum addresses the questions posed by Bill Murray of DOCS regarding the development of DRG base rates for DRG hospitals that do not have contracts with FCHPs. Each question is paraphrased below followed by our response.

***1. Can PwC provide a reconciliation of the “Projected Funding” in column A to the average inpatient cap rate?***

The attached exhibit shows a reconciliation within approximately 2%. An exact reconciliation would be quite time-consuming since very different approaches were used to derive the capitation rates and the DRG base rates even though they are based on the same underlying data. Additionally, certain simplifying assumptions were applied to deal with dual eligibles, for example, that prevent an exact reconciliation. Further, in the development of the DRG base rates, discharges with invalid DRG codes or DRGs without relative weights were excluded, whereas in the capitation development no discharges were excluded.

***2. What OHP enrollment level is assumed in the Projected Funding figure?***

The OHP enrollment level is irrelevant to the development of the DRG base rates since they represent unit cost reimbursement amounts and not per capita amounts. The projected funding figure simply represents the historical (July 1999 through June 2001) billed charges, adjusted by inpatient hospital cost-to-charge ratios and the cost component of trend. It is a “balancing” figure intended to demonstrate that the DRG-based payments (prior to the application of the 7.5% reduction) assuming all DRG hospitals are non-contracted is consistent with the funding built in the capitation rates for DRG hospitals. Other adjustments necessary to derive actual funding amounts, such as utilization trend and IBNR, were not applied since they have no impact on the calculated DRG base rate, but are shown in the reconciliation exhibit mentioned in the answer to Question #1.

***3. How has the new maternity case rate methodology been handled in the calculations?***

Maternity discharges were included in the development of the DRG base rates. Both the maternity case rate and the DRG base rates were calculated consistent with the funding amounts built into the capitation rates. The rationale for retaining maternity discharges is the presumption that, for deliveries at non-contracted DRG hospitals, the maternity case rate would be paid to the FCHP and a DRG-based payment would be made by the FCHP to the hospital.

**4. *Discharges look low, unless maternity has been excluded.***

Per the response to Question #3, maternity was not excluded. Bill would need to provide additional information to allow us to respond further to this issue.

**5. *How have Medicare prime members and their related hospital stays been handled in the calculations?***

Hospital stays for Dual Eligibles were retained in the calculation of the DRG base rates. As always, the encounter data provides us cost information limited to billed charges and insufficient information to calculate FCHP liability for Dual Eligibles without “re-adjudicating” the encounters, which requires substantial time and resources. We developed DRG base rates representing the full liability for the hospital stay by applying the cost-to-charge ratios and trends for the non-Dual population. Presumably, once the Medicare liability has been determined, the FCHP liability can be calculated by subtracting the Medicare payment from the “gross” DRG payment amount.

**6. *How were the Average Case Mix figures (column K) calculated? They look low, compared to the Medicare published figures.***

The Average Case Mix was calculated by multiplying the OMAP relative weight for each DRG by the corresponding number of discharges, summing the results, and dividing by the total number of discharges. This procedure was performed separately for each Medicare region using only DRG hospital data.

The demographic composition of the Oregon Medicaid population is significantly different from that of Medicare. Since the Medicaid population consists of a large proportion of young women and children, it is not surprising that the average case mix we calculated varies from figures published by Medicare for its population.

**7. *We have not received any documentation of the calculation of the outpatient rates. Can you provide them?***

An explanation of the development of the outpatient reimbursement for non-contracted DRG hospitals will be provided in a separate memorandum.

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Please call Pete Davidson at 415/498-5636 if you have any questions regarding this memo.

**Oregon Health Plan  
Reconciliation of DRG Base Rates for Non-Contracted DRG Hospitals with Inpatient Hospital Capitation Amounts  
FY 2004**

	<u>Composite</u>	<u>TANF</u>	<u>PLMA</u>	CHILDREN <u>00-01</u>	CHILDREN <u>01-05</u>	CHILDREN <u>06-18</u>	<u>OHPFAM</u>	<u>OHPAC</u>	ABAD- <u>MED</u>	<u>ABAD</u>	<u>OAA-MED</u>	<u>OAA</u>	<u>SCF</u>
1999-2001 FCHP Member Months	6,224,296	423,995	134,901	326,653	941,279	1,460,588	639,406	863,206	296,018	580,365	369,212	18,983	169,690
FY 2004 Inpatient Funding PMPM (including maternity and MH-Acute IP)	\$ 59.20	\$ 75.06	\$ 315.17	\$ 170.68	\$ 8.75	\$ 10.99	\$ 34.39	\$ 85.05	\$ 9.43	\$ 181.14	\$ 9.40	\$ 161.85	\$ 25.08
Dual Eligible Cap Rates Adjusted to Reflect Non-Dual Liability*	\$ 80.57	\$ 75.06	\$ 315.17	\$ 170.68	\$ 8.75	\$ 10.99	\$ 34.39	\$ 85.05	\$ 183.09	\$ 181.14	\$ 230.31	\$ 161.85	\$ 25.08
Total DRG Hospital "Funding"	\$ 315,806,680												
Utilization Trend Adjustment	1.1932												
IBNR Adjustment	1.0236												
Adjusted DRG Hospital "Funding"	\$ 385,734,934												
DRG Hospital as Percent of Total Inpatient Hospital Adjusted Charges	79%												
Total Hospital "Funding"	\$ 489,612,526												
1999-2001 FCHP Member Months	6,224,296												
Derived Inpatient Hospital Funding PMPM	\$ 78.66												
Ratio to Capitation Amount	0.98												

\* Dual Eligible cost-to-charge and trends replaced with those for non-Duals